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DEPOSITORY 376

Medicaid Management Information System (MMIS) Conference Report

Department of Health and Human Services/Health Care Financing Administration

HCFA

Louisville, Kentucky April 14-16, 1980

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THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) was established to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Professional Standards Review program and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries - approximately 47 million of the nation's aged, disabled and poor. The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

THE MEDICAID/MEDICARE MANAGEMENT INSTITUTE (M/MMI), within the Health Care Financing Administration, Bureau of Program Operations, works with Federal, State, and contractor staff toward improved management of the Medicaid and Medicare programs.

The M/MMI promotes program management improvements through problem analysis and technical assistance for corrective action, and fosters exchange of ideas and techniques through conferences, workshops, training and publications.

MEDICAID MANAGEMENT INFORMATION SYSTEM

(MMIS)

BENEFITS TO MANAGEMENT

CONFERENCE REPORT

LOUISVILLE, KENTUCKY

APRIL 14-16, 1980

Medicaid/Medicare Management Institute
Health Care Financing Administration
Department of Health and Human Services

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PREFACE

The Office of Methods and Systems, in conjunction with the Medicaid/Medicare Management Institute, sponsored the Second Annual Medicaid Management Information System (MMIS) - Benefits to Management Conference, April 14-16, 1980, in Louisville, Kentucky. One hundred and sixty-two persons attended the conference, representing thirty-one States, seven regions, several HHS offices, and twenty-four private sector firms.

The purpose of the conference was to share successful management experiences (both State and Federal resulting from effective use of MMIS) and gain insight into technological innovations and alternatives. Presentations were made by State and Federal staff and contractors.

The agenda included topics that were pertinent, inclusive, and interesting to participants. The conference was an excellent medium for the exchange of formal and informal communications among State and Federal governments and the private sector.

The high point of the conference was a presentation by the Bureau of Program Operation's Director, Mildred Tyssowski. Mrs. Tyssowski stressed the importance that HCFA management attaches to MMIS; the plan to use the common claims form by Medicare carriers; the move toward the paperless society or submission of bills in machine readable format; and, the use of the ICD-9CM for diagnostic coding for Medicaid and Medicare. Mrs. Tyssowski expressed her feeling that the decade of the 80's presents a tremendous challenge to all involved in management, and that a State and Federal partnership is a necessity.

This report is a compilation of major presentations made at the conference and also includes a summarized agenda and a list of participants.

SUMMARIZED AGENDA

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WELCOME TO KENTUCKY	Larry Huffman Commissioner, Bureau of Social Insurance Kentucky Dept. of Human Resources
CONFERENCE PURPOSE AND HCFA PERSPECTIVES	Mildred L. Tyssowski, Director Bureau of Program Operations HCFA
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THE SOUTH CAROLINA EXPERIMENT: COMMON CODING	Caroline C. Simmons, Director, Program Review Branch Division of Medical Care, Department of Social Services Columbia, South Carolina Charles Booth, Director, Division of Methods and Systems Requirements, OMS, BPO, HCFA
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	William J. Corboy, Chief Bureau of Information Systems, Division of Medical Assistance & Health Services New Jersey Department of Human Services Trenton, New Jersey
	Allen Z. Miller, MAMIS/CIS Project Director Pennsylvania Department of Public Welfare Harrisburg, Pennsylvania
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CONFERENCE PURPOSE AND HCFA PERSPECTIVES

Mildred L. Tyssowski
Director
Bureau of Program Operations, HCFA

MRS. TYSSOWSKI: I want to tell you that I really appreciate having a chance to speak with you this morning. I must confess that I've always been somewhat in awe of systems people, probably because there has been such a rapid advancement in computer technology during my career with the Federal government. Considerable time during this conference will probably be spent discussing computer technology, the state of the art, and so forth. But the real theme is "MMIS Benefits to Management."

And, as one of HCFA's managers, I want to share with you the importance that management attaches to MMIS and the initiatives in data processing that are underway in HCFA. These initiatives relate to the Medicaid program, the Medicare program, and to the third party payors in the health industry.

Now, I'll begin with some objectives for having this conference. As I said, the conference theme is "MMIS Benefits to Management." One of the objectives of the conference is to promote the expanded use of MMIS. During the last nine months, I've been directly involved with Medicaid programs, and I've been increasingly impressed by the great expectations management has regarding what this system can do for more effective administration of the Medicaid program.

Today, there are 28 States that have certified MMIS systems. Eight States plan to be certified during the current fiscal year; eleven States are in the planning and development stage; and, eight States or territories have no active plans.

I'm looking forward to the time when all States have certified systems. Then these annual meetings can truly be user meetings where experiences are shared and more effective systems evolve. Certainly the meeting this year is an opportunity to share experiences between those who have certified systems, those who are evolving new systems, and those who are still in the very early planning stages.

I think this conference also offers an opportunity to get acquainted with some of the new Federal leadership in the MMIS area. And since there have been changes in the States, I'm sure there are many people here who probably were not here last year. There are many people in the HCFA organization, like myself, who are still fairly new to the MMIS system. However, Bill Hogsten is perhaps one of the fathers of MMIS. Soon after the legislation was enacted regarding more Federal participation in the development of the MMIS, he was on a Departmental task force which did some early work on the concepts of the system. He also has his division directors here and I hope you'll become acquainted with them. There are other people from the Bureau of Program Operations who are involved with standards, statistics, and finance. Also, there are other HCFA and Departmental representatives attending the conference. So I hope you'll have a chance to get acquainted with the Federal people and the State people. Also, it's a chance for us in the Federal government to give you some feel for our new initiatives and perspectives, and for you to give us your input, your advice and consultation.

I think that in the area of getting your input as State government employees involved in this field, we have made considerable progress in the past year. A year ago, HCFA launched what is called NTAG, the National Technical Advisory Group. It's done a tremendous job in giving assistance and advice in the whole development of the MMIS system, particularly in the standards area.

We have now moved into a more formalized structure for getting State input and advice. This structure involves a group called the State Medicaid Directors Group (SMG). They are already in operation and several technical advisory groups have been developed in the areas of systems, finance and reports. The group for systems is called STAG, and will be meeting at the close of this conference.

I think the dialogue between State and Federal government, provided by this structure, should be beneficial in all aspects of the administration of the Medicaid program.

In looking at the agenda for this conference, I think it offers an opportunity to achieve the objectives that I have outlined. It provides for considerable indepth discussion at the working level staff. It also permits an interaction between State and Federal officials in many of the panels. I think some of the topics you have selected are of very high priority, topics such as performance standards, coding, and Medicaid data base development. And, perhaps even more important is the unwritten agenda: the opportunity to discuss mutual problems in the halls, the coffee breaks, the cocktail lounge, etc.

Now, back to the conference theme, "MMIS Benefits to Management." On March 21st, Secretary Patricia Harris testified before the House Subcommittee on Oversight and Investigations, and one of the topics for inquiry at this congressional hearing was the MMIS system. Secretary Harris stated, "Improving State Medicaid management practices is cost effective and one of the Department's highest priorities. MMIS is a tool which holds great promise in this effort, but one which States must be prepared to implement carefully if it is to result in significant savings or efficiencies."

Her appearance before this House subcommittee was in response to that subcommittee's impatience with the progress we have made since 1972 in the implementation of MMIS.

Some of you are also familiar with the Schweiker amendment. It was a proposed amendment to a piece of child welfare legislation, and would set statutory deadlines for installation of MMIS systems. The Schweiker amendment has not yet passed the Congress. But I think it's reflective of the impatience in the Congress with how fast we are moving to install MMIS.

Perhaps the desire to get on with the job is closest to you who work directly in installing these systems in the States. I'm sure you face the day to day frustrations that come from developing and installing any data processing system.

We in HCFA are also keenly interested in seeing that the certification process moves as expeditiously as possible. We are also interested in the effective utilization of the 90 percent development money. For that reason, in the past several months, we have been working with some States that have been having difficulty getting their system underway, difficulty in developing schedules of deliverables and meeting those schedules to permit continuation of 90 percent funding. So we are trying to give a little financial nudging to the development and installation of MMIS systems.

But certification really isn't the end all. I think Len Schaeffer expressed this a year ago when he met with this group. He said that the Federal government cannot really walk away from the system once it's certified. Instead, we need to continually measure whether the system is achieving the objectives that it was established to achieve. To accomplish that goal, we need to review systems that are already certified and determine whether they are continuing to achieve the objectives they were established to achieve. Additionally, we are tyring to develop ways to measure whether a system is actually functioning as it was intended to function.

In that direction, standards are being developed for recertification of MMIS systems. Some of these will be incorporated in the original certification. There has been a lot of work in this area in the past year by State people in the NTAG and by Federal officials in the Bureau of Program Operations. Our objective is to have some standards established before the end of this fiscal year.

You have a session on standards scheduled for tomorrow. I know this is an area of great interest to you. Once you establish standards, you have to establish a mechanism for assessing whether or not these standards are being reached. We are trying to fold that process into the State assessment reviews in a larger way. You have a session on that, too.

There are other priorities in HCFA's plans for the MMIS system. One is to fill in some gaps in the general design. One of the gaps that we hope to fill in the current fiscal year is in EPSDT. We want to improve the subsystems, and one we've earmarked for highest priority is the SUR system. Our plans include a revision of the general design to make it more output rather than process oriented.

I'll turn to some of the HCFA initiatives in information systems and claims processing which cut across Medicare and Medicaid programs, initiatives that affect the health industry in total. Today, the Medicare and Medicaid programs serve 47 million people. In 1980, the Federal government expended $47 billion to purchase services in these two programs. You have just heard that in Kentucky the Medicaid program is one of the highest budget items in the State. Such is the case with the Medicare and Medicaid programs in the Federal budget. Certainly this amount of Federal dollars has a major impact on the entire health industry.

Included in the packet that was handed to you at the registration desk are some discussion papers that have been developed by HCFA. Two are of particular interest: one on the commmon claims form and one on common coding.

In an effort to achieve a dialogue with all the parties interested in the Medicare and Medicaid programs, HCFA developed a series of discussion papers. We invite the comments of all people affected by various proposed HCFA policies. This is in addition to the usual comments that result from the regulatory process. Once we have a dialogue with all concerned parties, we plan to issue a final decision paper.

There are a couple of areas that HCFA has moved to the decision point. One deals with a common claims form for physician services, and the other involves common coding.

Last year at your conference, you were given a run down of the integration projects on which the Medicare Bureau and the Medicaid Bureau were working. With the reorganization of HCFA's central office on a functional basis, most of these projects are now part of the Bureau of Program Operation's regular workload.

First, I'd like to talk about the common claims form. This form is based on one that has been developed by the American Medical Association and, of course, other third party payors in the commercial insurance industry and the Blue Cross and Blue Shield Association. We sometimes refer to it as the "AMA form." It's presently being received by 12 Medicare carriers, 15 Medicaid claims processors, and 33 private insurance organizations. You might ask, "Why the common claims form"? The answer is that this is one of HCFA's efforts to relieve the paperwork burden on providers throughout the country, to facilitate the submission of data by the use of common forms.

We plan to require the use of the common physicians' claims form by Medicare carriers in the current calendar year. In effect, we're going to use all the old Forms 1490 and move into the new claims form for Medicare.

We need to talk further with you regarding how we can implement this in Medicaid. I think there are approximately 15 Medicaid claims processors using it already. We hope that as the Medicare carriers use this form, additional States will want to adopt it as well. I guess the question that will eventually come is at what point in time we want to mandate this form for Medicaid use. We will be discussing this issue a lot with you. In the interim, for those of you who are planning new systems or have a major systems' change underway, I think it behooves you to take into account our plan to implement a common claims form.

Another area where a decision has been reached is the common coding systems, or labeling systems. HCFA has already set forth a requirement for the use of ICD-9CM as the diagnostic code for Medicare and Medicaid. I regret that there was some initial confusion in all this, particularly relating to the Medicaid program. I think we are now on track; this is the requirement insofar as diagnostic coding is concerned.

As concerns procedural coding, the Administrator has made the decision and has reached agreement with the American Medical Association on the use of a CPT-4 base sytem. There are two stages involved in this. One is the development of a long range system to cover all services in all settings. Second is the process of developing a shorter or interim range system to cover fee for services, largely from physicians and suppliers. This is what the pilot in South Carolina is attempting to do.

In this pilot, CPT-4, as now set up, covers only physicians' services. It is being expanded to cover suppliers, durable medical equipment, for example. It is also a way of developing a model for cross walking from your existing coding system into the CPT-4 base system without creating inflation.

So, this is one of the two major purposes of the South Carolina system and you will be talking about that in more depth in this afternoon's session.

In order to achieve a gradual transition of the Medicare contractors and the Medicaid State agencies to common labeling systems, it is the intent of HCFA to approve systems changes only if they reflect the change to the new coding system. By the end of the calendar year, we hope to publish a regulation which will outline this decision to require that all Medicaid programs use a HCFA approved system for diagnosis and procedural labeling. We have not yet published a regulation on the diagnostic code, and we hope to combine that with something on the procedural code. This common coding is, as all who have been working in the systems area know, a very vital link for exchange of data between the health systems of Medicare and Medicaid.

One other principal initiative that I would like to talk about is our movement toward a paperless society. At the present time, we're involved in a tremendous paper claims process in the Medicare and Medicaid programs. Between the two programs, some 500 million claims are handled every year. That's a lot of paper. Our interest in Medicare and Medicaid and other third party payors is to move as fast as possible to reduce this paperwork burden.

As many of you know, many hospitals, some with less than a hundred beds, keep admission and billing records by computers. And more and more of the hospitals are computerizing their own operations. And I guess that more and more physician services are billed by computer devices. We need to capitalize on this effort in the health industry, and have begun working with some States, Medicare fiscal intermediaries, and private groups, such as the American Hospital Association, Blue Cross, and the Health Insurance Association, to move toward submission of bills in machine readable format.

I don't need to emphasize how important it is that we be the leaders in this field. There is much to be done. By June 1980, we hope to release the format that we would propose for the Medicare and Medicaid programs for submission of machine readable data. This is just the beginning of how we can capitalize on effort underway in the private sector of the health industry to eliminate much of the paper pushing.

I think it suffices to say that the decade of the 1980s certainly presents a tremendous challenge to all of us who are involved in management systems. I think this conference will be a very important stepping stone to our working together in meeting our common objectives in this area.

I thank you for inviting me. I plan to stay throughout the day and will be happy to talk with you individually. Now, if you have any questions, I'll be happy to answer them. Thank you.

WELCOME TO KENTUCKY

Grady Stumbo, M.D.
Secretary, Kentucky Department of
Human Resources

DR. STUMBO: I'm a rural practitioner from a little town of about 400 in Kentucky, and I now find myself doing battle with computers and some of the terminologies that're thrown out here, MAS-4s and MH this.

My relationship with MMIS basically reminds me of an uncle back home. If you come from where I come from, the ability to shake one's hand isn't easy. If you've ever noticed mountain people or Appalachian people, we really don't like physical closeness. A distance between people is important to us, and, basically, having people touch me causes me, culturally, to feel uncomfortable. I mean that's just the way it is. Excluding funerals, church and politics, mountain men rarely shake hands. Now, if a mountain man shakes your hand, other than those three circumtances, that sort of conveys everything. That conveys word, honor, integrity.

One day, my uncle sold some land to a place to build a hospital. This was way back in the '50s and I was a little boy. They had a lawyer from Philadelphia come down, that's true. He came down and they fixed a contract out and my uncle signed it. And my uncle stood there, kind of shifting around, and they said, "What's the matter, Henry? You signed it and you'll get your money." He said, "Well" -- he looked at the man, the lawyer, and he said, "You know, me and that man, we've had it, but we ain't never shook."

And that's kind of like me and MMIS; me and MMIS, you know, we've had it, but we ain't shook on it yet. Well, I'm working hard with HCFA, trying to shake on it.

I, basically, find myself now, being a rural practitioner come in; the first physician to be this high in the State government and the first physician Secretary of the Department of Human Resources. There's a great deal of interest in primary care.

I think our State is going to enter into a program of reallocation of monies from institutions into primary care. I specifically think the kind of management people that Governor Brown has brought in with him -- young, no government tradition -- they're managers; they're people who, in their own right, have established a priority.

I think in our own department, the head of Social Insurance, Commissioner Huffman represents that kind of person. I think more specifically to this group and MMIS, Robert Neisham represents Kentucky's new approach to say, you know, "it's time to shake on it and get on with the business."

I think there's no question about MMIS in Kentucky, I think we've been foot dragging. I don't think it has been the Feds' fault; I think it's been our fault. I think we've just simply not shouldered that responsibility. I think we've been sort of self stroking ourselves with a system that, in many ways, is too complicated. I like the approach that Bob Neisham is taking to get us down there. I think the Federal government and the State of Kentucky are going to have a real good relationship over the next 12 to 13 months or so.

I think I basically take a "good ole boy's" approach to most of this government stuff. Waltzed down to Atlanta the other day in a pair of Levi's, and walked in to see all the big fellows; they were a little bit confused that I was there - shaking hands with my executive assistant, because he had a tie on. I finally had to give him a cowboy hat -- I was ready to take his tie away from him and put it on. James Hicks walked into my office the other day -- he's a man from back in Knott County. He told my secretary he wanted to see Grady Stumbo, and she said, "You got an appointment?" He said, "I don't need one." She said, "Well, I'm sorry, sir, you know he's awful busy." He went on and he said, "Well, you go in there and you tell him that it's the man that built his house who is down here to see him." So, she thought, at that point, she'd better go in. I came in and sat there, rocking. James looked around and stared, and he said, "I'm right impressed, right impressed, Doc." He says, "You done all right for youself." And when it was all over, I said, "Well, James, what do you think about this place?" He said, "You know, I just don't think it's ever going to amount to anything." And I said, "Well, how come you say that, James?" And James said, "Doc, this is just too far away from every place." And you know, sometimes I said that to the people working in our computer shop, "Look, sometimes you fellows are just too far away from where it's at. You've got to simplify what it is you're doing. You've got to make it applicable and not get it so complicated that us common folks can't understand it.

And I think if you do that, I have no question in my mind that the basic principles behind the MMIS can go a long way to doing some of the kinds of things of looking at where our cost centers are, where we can reallocate resources.

So, I think, on behalf of Governor Brown, I'd like to welcome you all to Kentucky, and we hope that you'll find your stay here enjoyable. And, basically, what you see now in Human Resources is about what you've got, you know, but we're hard working people, but common folks. We'd be honest with you, straight-out, and I think that's what governments lack, particularly in our department.

This year, we've got a Governor that's different; we've got a legislature that's different; you've got a Secretary of Human Resources that's different; and, I can tell you that our department is going to be different.

Thank you.

BRINGING PUBLIC PROGRAMS UNDER CONTROL

Lloyd Moses
Associate Commissioner for Medical Systems
and Operations
New York State Department of Social Services

MR. MOSES: Good morning. The following discussion reviews the present day Medicaid Management Information System in New York State. In it you should recognize elements of similarity between this and those existing elsewhere. But most important for this audience, I think, will be a view I have of New York's experience with managing Medicaid, both before and after the development of an automated information system. I think this because the experience has been unique in certain ways, and because any number of lessons can be drawn from our record of progress.

What we have now in MMIS is the end product of a complex, multilayered balance struck between three competing forces and conditions: Federal approaches in design and regulation; State legislative mandates; and, a myriad of local operational concerns. These forces overlap at points and contradict each other, but always require integration and management. But let me start at the beginning with the background of our effort.

The Medicaid program in New York has several distinctive features reflecting our State's special character, size and history. It may help to preface my remarks this morning by recalling that in terms of population, New York is the second largest State. It occupies an enormous land area, and is the home of one of the world's largest and most dynamic cities. Its population is ethnically diverse, containing substantial communities of Chinese and Hispanics, French speaking Haitians, and numerous other nationalities. The counties within the State of New York reflect both the highest and lowest population densities per square mile to be found anywhere in the United States. Along with the other northeastern States, our social services programs have been challenged by the extremes of change which have characterized that region's experience of the last two decades. Each and every one of these factors confronts and complicates administration and control of assistance programs.

Consider, for example, that New York's Medicaid program is the nation's largest and accounts for a full 20 percent of the total Federal outlay each year. There are currently more than two million persons in New York State who are eligible to receive medical assistance. Last year, this group -- fully ten percent of the State's total population -- consumed almost $4.5 billion of medical services. These figures, considered in any light, are awesome; yet, large as they are, these dollar expenditures are likely to continue growing in response to present economic conditions.

New York offers a broad and varied spectrum of services and assistance to its needy population and is unique because it does this by means of a delivery system that is locally administered and centrally supervised. There are 57 separate jurisdictions in addition to New York City's five boroughs, which constitute one single unit. New York City, alone, accounts for 65 to 70 percent of the State's entire Medicaid clientele.

In an effort to provide quality health care to the many medically needy within the State, the legislature passed, and the Governor enacted, the Medicaid program in April of 1966. The program was, from the start, and continues to be one of the most comprehensive of all Medicaid programs in the nation. In terms of who is eligible, Medicaid pays for health care services for persons: receiving cash assistance in the Aid to Families with Dependent Children, Supplemental Security Income, and general assistance programs; for the medically needy who are not in receipt of a cash grant; and, for the excess income or spend down clients whose Medicaid needs exceed the medical assistance only eligibility levels.

In addition, New York State has a catastrophic illness program for inpatient hospital care for those persons between the ages of 21 and 65 who are not blind or disabled and who do not qualify for a general assistance cash grant. The services provided by the State to the Medicaid population are the maximum number of optional services which are Federally reimbursed. In 1968, there were 835,000 clients, and this figure quickly rose to 2.3 million by 1970. So explosive was this growth that it stretched the capacity of local administrative units to the limits, and created an intolerable financial burden.

Wholesale administrative difficulties beset Medicaid from the start, but these were compounded in the Empire State by the unfortunate conjunction of historical and economic forces. A weakening national economy and rising inflation forced up taxes and drove businesses and jobs out of our cities. While health care expenditures in New York State have risen rapidly, this situation is far from unique and is a problem shared by everyone in this room.

The increase in national health care expenditures during the period 1965 to 1978 far outpaced the growth of the American economy. While the Gross National Product rose by slightly over 200 percent during those 13 years, the expenditures for health care rose even faster, reaching 350 percent. Health care expenditures in the public sector were the primary contributor to this astounding increase. The net effect, from our perspective, was a swollen list of Medicaid eligibles, extreme taxpayer sensitivity to welfare budget increases, and alarm over the amounts in those expenditures that apparently could not be controlled or accounted for. In addition, there were, of course, some clients and some providers who were bent on defrauding or otherwise manipulating the program to their own ends. Given these circumstances, accusations of poor management and control were virtually inevitable and, within New York City, always a special case. The entire scenario was played out in an atmosphere of continued crisis and repeated alarms. Quite obviously a means was needed to give program managers a degree of control over the elements of the program which otherwise would continue to drain the State coffers.

But traditional responses had already been shown to be ineffective in restraining Medicaid expenditures. Unrelenting growth had brought in its wake a series of legislative moves to reduce the outflow of funds. Amendment after amendment to eligibility standards were made in 1968 and again in 1977, all to no avail. The failure of these actions, in conjunction with the deepening fiscal crisis in New York City and New York State, demanded innovative and creative approaches to replace ancient concepts.

To remedy the inconsistencies and varying interpretations of Medicaid regulations by 57 independently operating social services districts, and to reduce the spiraling Medicaid budget without severely constricting New York's traditional broad scope provision of services, the State legislature, in June of 1976, enacted bills mandating the State's assumption of Medicaid operational functions and authorizing the creation of Statewide automated information system to assist in the management of Medicaid. Following the establishment of the necessary personnel and hardware structures, the State would assume operational responsibility for Medicaid, excluding only the eligibility function, which would remain with the local districts. This creation of New

York's MMIS was a first step in a much larger commitment to automate, to the fullest degree possible, our entire social welfare program and all of its administrative supports. A Medicaid management system was clearly necessary for New York City and was also viewed as a controlling mechanism for the administration of the Statewide program.

While the project envisioned by the State's planners was ultimately Statewide in its scope, local conditions would dictate implementation strategies and specific timetables. The immediately pressing need was in New York City where, as I have noted, 65 to 70 percent of the State's Medicaid budget is expended. Implementation of the districts outside of New York City was to follow in subsequent stages. Provision in the Federal guidelines made it possible to employ a fiscal agent, thus enabling the State greater latitude in attacking the problem at hand in New York City. The Department would need that freedom of movement since the Legislature had created special challenges for the agency. In May 1976, the agency, as we have come to realize, began its transformation into a new entity, one which would now share operational responsibilities with the very local districts it had previously dealt with in only a supervisory capacity. The assumption of these new responsibilities has created a new State and local partnership, the success of which will benefit all citizens of New York State.

The major initial challenge was for a traditional social services agency to become an innovator and leader in the field of data processing. In 1975, our department had virtually no data processing capability and, as a whole, had only 1600 employees. Today, in the Management Information Services Division alone, there are over 1200 employees who interact and perform data processing services for every aspect of departmental responsibility. Our inhouse data processing capabilities are now second to none, but so are our current responsibilities. We have had to constantly upgrade our systems performance as our legislative mandates multiplied.

Our first major development and implementation task concerned MMIS in New York City. After an indepth review of data processing proposals submitted for the development, implementation and operation of New York's MMIS, Bradford Administrative Services, Inc. was chosen to act as the fiscal agent for claims processing in New York City. In May 1977, Bradford began work with the department that culminated, only five months later, with initial MMIS operations in New York City. The paramount concern of the Department of Social Services for its emerging operations in New York was systems reliability, since user confidence could be gained in no other way. To put it bluntly, the Department needed a good, clean success.

In my opening remarks, I stressed that among the requirements we were pressed to meet were local operational concerns. Systems implementation, under the best of circumstances, is often trying and, in New York City, we worked with a degree of difficulty and complexity that would be, indeed, hard to duplicate anywhere else. To illustrate, there did not exist any single file of all New York City Medicaid eligibles. Files from the various New York City offices were in different formats and had to be converted into consistent data elements before a centralized file could be created. There were duplications on that file which New York City had to resolve as well as systems constraints in backdating eligibility. The problems encountered in New York City and our method of dealing with them would serve as a model for the future. While few exact parallels with New York City exist, it can be said that New York City was the definitive local situation. We established there the principles which have since governed all our efforts.

All the various agencies and users were compelled to cooperate in finding solutions and in reaching decisions which, in hindsight, were crucial to the success of MMIS implementation. More important, the success of this initial effort would validate our commitment to automate social services programs across the entire State. The Department of Social Services, the Department of Health, the Human Resources Administration of New York City, and Bradford cooperated totally with HEW in the watershed decision to implement MMIS in phases, another move dictated by local circumstances in the city. Under this approach the provider community was divided into four major groups. Twenty-one separate provider categories were to be brought on to the system incrementally over a period of less than twenty-four months. Phased implementation, with a minimum disruption to provider billing practices, was therefore planned.

Beginning with physicians and clinics as the first group of major importance, both within the community and crucially important to the quality of the Medicaid programs, MMIS began operation on November 1, 1977. The New York State MMIS became operational for pharmacy and hospital claims on April 1, 1978, and June 1, 1978, respectively. Within one year after the selection of Bradford as New York State's Medicaid fiscal agent for the city, approximately 70 percent of all city providers, comprising approximately 70 percent of the New York City Medicaid business, had been successfully converted to the State's MMIS operational mode. With the completion of all New York City's provider groups, the stage was now set for phased implementation of New York's remaining districts, geographically by region.

After an intensive onsite HEW review, certification of the first three phases of New York's MMIS was announced by then Secretary Joseph Califano on January 6, 1979, and the remaining provider groups were certified on October 22, 1979.

In the context of this morning's topic, "Bringing Public Programs Under Control," allow me to quote from Secretary Califano's certification statement: "The progress which has been made here in New York over the past fourteen months demonstrates that the Federal government and our States and cities can work together to make better use of tax dollars."

Specific benefits achieved through the automated claims payment system were evident in one form or another from the first day. Let me briefly mention some of them:

- There was elimination of duplicates and overbilling practices, long prevalent in the city.
- Timely processing of valid claims became the usual rather than the exception: most claims are paid within ten working days.
- More uniform program administration was achieved through the standardization which MMIS requires.
- Providers received weekly remittance statements as to the status of the claims which they had submitted.

o The system provides for program integrity through an internal edit structure which assures consistency and the legitimacy of service delivery. At this time there are approximately 1,300 to 2,000 edits, depending upon the provider group, in our system which are all aimed at assuring payment for only legitimate services from legitimate providers.

While it is true that a major focus of MMIS is directed to the efficient and cost effective handling of Medicaid claims, we must not overlook the fact that a major benefit of the system is its ability to provide management with timely and accurate data. New York State's Surveillance and Utilization Review System, SUR, and the Management and Administrative Reporting System, MARS, have each proven individually to be effective management information tools.

The MARS system has become the focal point for providing systems information concerning New York State's Medicaid program. The issuance of MARS reports represents a revolution in information technology for the Department's Medicaid program. Program control prior to MMIS was hampered by the long period between the initiation of a program action and the sure knowledge of its consequences. The "feedback loop" for program managers was excessive and unacceptable. For example, the previous expenditure reporting system required at least six weeks after the reporting time period had ended to accumulate the financial data. Now, with MMIS this has been reduced to three days after the end of the reporting period.

Not only has the time frame for reporting been dramatically reduced, but also the existence of MMIS allows qualitative improvement in program control through quantitative techniques. Prior to MMIS in New York State, econometric modeling of the program as a monitoring and forecasting tool was extremely difficult to perform because of the lack of sufficient data of acceptable quality. With the present reporting system, the quantitative relationships between, say, the unemployment rate and expenditures for the medically needy can be explored. Variations in expenditures can be explained; control can be established.

MARS reports also represent a revolutionary change in the administration of Medicaid policy and provide a common framework of data for various State agencies involved with the Medicaid program. Numerous other State agencies now presently receive MARS reports, including the Department of Health, the State Division of Budget, the Comptroller's Office, and the Office of Alcoholism and Substance Abuse. Joint decisions are more readily obtainable on such issues as the impact of new Federal or State regulations or the establishment of fees, rates and prices for services rendered to Medicaid recipients. This represents, for the first time in the history of the Medicaid program, a synergistic approach made possible by the common data base provided by MMIS through its MARS reports.

The second reporting system, SUR, has generated key postaudit data for our program management staff which has been used in ongoing policy and administrative analyses. It has also generated unique data on client and provider usage which has already resulted in program dollar savings.

A pertinent example of one outstanding SUR success was a special program to identify recipients who were abusing the Medicaid system in relation to drugs. This program restricted the use of the medical assistance ID cards to clients identified by MMIS as Medicaid abusers in New York City. By limiting that particular group so that they could only obtain services from one pharmacy, specified in advance, we were able to achieve a monthly reduction in their average bill for drugs from $212 a month to less than $16 per month.

SUR also provides data relative to provider abuses such as "ping-ponging" and delivery of excessive services. As a result of SUR reports which can identify patterns of service which substantially deviate from established norms, a number of providers have been singled out for investigation and either prosecuted or suspended from the program for abuse of the system. It is only through these and other similar efforts that program administrators can weed out the small but costly group of recipients and providers who attempt to subvert the system to their own ends.

As we all know, program dollars are severely limited and we cannot afford to waste them. MMIS gave us the ability to begin to manage the financial component of the Medicaid program. This is particualarly evident in the area of third party resources. Through an emphasis on third party health insurance information, we have begun the process of tapping a long ignored and neglected resource, so that Medicaid actually becomes the payor of last resort. Studies have shown that on the national average, eight percent of all Medicaid recipients have some form of third party coverage. In terms of New York State, this eight percent converts to approximately 160,000 recipients and about 4.8 million claims per year. Utilizing the average claim expenditure, we could develop an annualized cost savings. But, I really believe it is premature to do so, namely due to the fact that our efforts in this area are in their infancy and additional enabling legislation is required which would persuade the entire insurance industry to cooperate with us.

As part of our third party efforts, the New York State Department of Social Services has signed agreements with Blue Cross and Blue Shield corporations which, for the first time, allow for searching their files and actually billing them directly. As of December 31, 1979, the Department has recouped over $1 million from Blue Cross-Blue Shield of Greater New York for bills paid by Medicaid which should have been paid by Blue Cross. Additional recoupments are expected in the future as the Department continues its efforts to recover these funds from third party health insurers.

In addition to recoupment, the cost avoidance estimate for third party liability for the third quarter of 1979 was approximately $98 million. We anticipate expanding the commercial insurance carriers and, at that point, cost savings should be magnified many times. We are also presently trying to implement a variety of crossover systems and agreements with other payors. A key ingredient to the success of a major systems' implementation of this magnitude is the time and attention paid to the human aspects of the operation. For MMIS to succeed, it was essential to establish an atmosphere of understanding and cooperation with the provider community. With the professional provider relations and training effort led by our fiscal agent, the obvious advantages of MMIS resulted in new provider confidence. Previously, there was minimal participation of primary care physicians in the city program, approximately 4200 before MMIS. Today, the figure is well over 10,000. To have more doctors at the first line of medical service delivery continues to be a major goal of the Medicaid program. Provider relations staff from both the Department and the fiscal agent were able to build effective channels of communications with providers and thereby ensure a smooth transition period from locally administered programs to one primarily administered by the State. In the course of converting the New York City program, alone, MMIS has trained over 15,000 providers.

One especially difficult problem that we experienced concerned a provider's ability to access our toll free hot line numbers on questions involving recipient eligibility status. Although our hot line system accomodates approximately 40,000 calls a month, it soon became evident that we simply could not handle the volume of incoming calls dealing with eligibility through the hot line. To resolve this problem, we investigated a variety of alternatives before deciding a pilot test, a telephone transaction system which was developed by Western Electric. The system utilizes an especially developed touchtone telephone, with the capability of receiving eligibility information from the MMIS computer and transmitting it directly to the small display screen on the face of the telephone. The system can instantly tell the provider current eligibility status, the existence of Medicare or third party liability insurance, and "spend down" or exception codes pertaining to the recipient's coverage.

The system, the first of its kind in any MMIS program in the country, has already proven to be a valuable asset to providers, and we are now examining the possibility of expanding the program to accommodate additional numbers of our high volume providers.

I do not want to give you the impression that everything in New York is all well and marvelous. Major difficulties persist. Primarily, they are related to the lack of timely eligibility determination, incomplete and inaccurate data on all aspects of eligibility, and the persistent inability of most of our counties to correct the situation. Any provider doubt that seems to remain regarding MMIS is directly attributable to these eligibility issues. While the solutions to these problems ultimately lie in reshaping the larger eligibility process, new procedures, especially for handling pending claims and particularly inpatient hospital providers, have been incorporated without any noticeable further dislocation. However, MMIS, by itself, was never intended to become a comprehensive elgibility system. For its part, MMIS has continued to strengthen its own performance. It has responded to continual executive audits, program changes and systems interfaces by seeking innovative and unique system solutions to a variety of complex and longstanding problems.

Troublesome as these eligibility issues have been for MMIS, they are not exclusive to Medicaid. Quite the contrary, since for each service and assistance program eligibility is a requisite first step. It is the key operational decision - allowing or denying access to benefits. The really salient issue is who does it. In New York, the gate to benefits is opened or closed to a client by the local district. It is the principal local responsibility and it is crucial to the integrity of social services programs. So important is it that we have embarked on the most ambitious project in the nation to guarantee the availability to uniform eligibility information and reduce, if not eliminate, fraud.

The Welfare Management System, WMS, was given its charter simultaneous with MMIS in the summer of 1976. WMS has been designed as an umbrella system, the larger entity into which all other systems will fit. As a host system, WMS maintains all up to date and correct eligibility data required by MMIS. New York welfare managers have had a long look at the full system in operation. WMS interfaced with MMIS in three upstate counties prior to implementation across the State. So far, however, no evidence of the eligibility problems which beset the system in New York City have surfaced in any one of the three pilot county operations. Even in the largest of the three counties, Nassau, which borders New York City and shares some of its characteristics, MMIS has operated successfully since October of 1979.

Buoyed by this record, the Department has been able to turn its full attention and resources to the job of implementing and operating the system and the MMIS interface across the State. What remains to be done is to install a Welfare Management System in the largest of all districts, New York City. Fortunately, both the city's Human Resources Administration and State Department of Social Services recognized the opportunity that WMS represents. The mandate to install WMS is the opportunity to close wide gaps in the city's systems as presently configured; to trace and isolate the source of enduring difficulties; and, to coordinate and systematize the crazy quilt of New York City's teleprocessing and telecommunications network.

In addition to the WMS and MMIS connection, the New York State Department of Social Services has committed itself, as an agency, to the full support of systems development that will assist its management in the execution of service programs across the wide spectrum of human needs. This aggressive advocacy of centralized automation has put the Department into a favorable developmental position on a number of new systems issues. This is true particularly in the case of MMIS for which interfaces are currently being developed with three additional major developmental projects: the Child Care Review Service, the Comprehensive Child Support System, and the Financial Management System. The interaction between these various systems will result in the improved effectiveness of each, leading to direct and indirect savings for Medicaid. Taken together, each of the systems becomes much more effective than it would have been in isolation.

The Child Care Review System is a management information system which greatly improves the State's ability to carry out its case management responsibilities towards the 42,000 children who are in the care of the State. To the extent that this management system succeeds in increasing the number of placements of these children in permanent homes and moving at least some of them out of the Medicaid coverage and onto private insurance plans of their families, this system will indirectly aid in reducing medical assistance costs.

The Child Support Management System is a State operated system to manage Title IV-D cases. Participation by counties is voluntary. Eighteen are currently participating and seventeen more are scheduled to be added in the future. This system combines several closely interrelated functions, including an expanded version of the parent locator service, an automated support collection unit, and a case tracking system. The parent locator service's efforts to locate missing parents may produce evidence that the absent parent has third party insurance which may cover the rest of the family. Likewise, payments by parents directly to the automated support collection unit, by contributing to the income of a near poor family, indirectly decreases Medicaid costs.

The case tracking system allows the Department to track the involvement of a child support case through the various social services programs, including Medicaid and ADC, and provides for a sharing of information between the various programs. For example, the ADC program may receive indications of a missing parent's location and would notify the Child Support Management System to investigate further. The result could be the offsetting of the costs of some ADC benefits. The Child Support Management System illustrates how the various EDP systems interact for a mutually enhancing effect.

The Financial Management System will provide the Department with a comprehensive capability to monitor, plan and project the cost of its various programs, including, of course, Medicaid. This system will be closely interfaced with Medicaid, which will provide Medicaid expenditure data. The Financial Management System will allow the Department to consistently predict future expenditures and accurately control current expenditures. The system will bring the Department's financial administrative capabilities up to the level required by the trend to centralize administration and information of major State social programs.

The Financial Management System will make its contribution to Medicaid administration and planning by providing the State with the "big picture" and by enabling administrators to consider Medicaid in context of all of the Department's programs.

A variety of other fiscal and management control systems, such as wage reporting, etc., are also in the act, but I think we've covered enough areas. When these various management systems are fully operational and effectively functioning, MMIS will be a mature system and constitute a major instrument for program control. Information flow between the various interrelated programs will be optimized, particularly in areas affecting eligibility.

Thus, despite the staggering sums and enormous client population noted in the beginning of my address, there is little doubt that our systems' effort -- already producing benefits beyond those predicted for it -- will ultimately give the Department the means to comprehensively survey its activities, to make accurate forecasts of future needs, to effectively deliver the services it is charged to deliver, and, to maintain a level of control over public programs previously unheard of.

New York's experience, over the course of the last three years, should be instructive to other States. We have learned that the full benefits of MMIS, in terms of improved administration and management, in terms of reducing fraud and abuse, and in terms of savings, can only be fully realized with the development and implementation of coordinated and comprehensive management information systems for the delivery of social services.

Thank you.

THE SOUTH CAROLINA EXPERIMENT: COMMON CODING

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MS. SIMMONS: First of all, I have to say that I'm sorry that my counterpart from the Medicare carrier could not be here this afternoon, but he is busy back in South Carolina doing the project.

Before discussing the specifics of the South Carolina project, I think it would be appropriate for me to give you a little bit of a history.

The Medicare carrier in South Carolina is South Carolina Blue Cross and Blue Shield. They were also the Medicaid fiscal intermediary between July 1973 and August 1979. During the interim, the providers utilized a common claim form as well as a common provider manual. Also, in the absence of conflicting Title XIX guidelines, Title XVIII guidelines were adopted as coverage guidelines.

In early 1977, our agency received the green light to begin planning and developing our own MMIS system. After much research, we decided to base our systems design after Minnesota's MMIS. By August of 1978, a decision had been made to utilize the following coding systems on the claim forms submitted: 1) the ICD-9CM diagnostic coding scheme, all five digits; 2) CPT-4 codes for physicians, podiatrists, labs and X-rays; 3) ADA codes for dental providers; and, 4) NABSP codes for all other categories of service such as chiropractors, DME. ICD-9 was selected for use because it was advanced and comprehensive. Its use had been endorsed by the South Carolina Hospital Association and, in December of 1978, we received an information memorandum mandating implementation by January of 1979, including our PSRO. This requirement was restated in a HCFA memorandum to all Medicaid programs. ICD-9CM is not included in our project. Medicare, unlike Medicaid, cannot mandate that all claims coming in be coded. CPT-4 coding was adopted for several reasons. It is an excellent utilization review tool in identifying specific services rendered. It was also felt that there was an excellent chance that, at some point in time, this coding scheme would be mandated, nationwide, for Medicaid and Medicare. In addition, the South Carolina Medical Association endorsed use of the CPT-4 coding scheme, and this was reemphasized by the Medical Association in 1978 and in early 1979.

In 1979, Blue Cross and Blue Shield of South Carolina expressed a desire to implement CPT-4, since we were using CPT-4, and asked the regional office and Baltimore for clearance. They received substantial support from the South Carolina Medical Association, DSS and political figures. Permission was subsequently granted and Medicare began accepting CPT-4 codes in January, with full implementation to be July 1 of this year. Medicaid has been using CPT-4 since August 1979.

Simultaneously, South Carolina representatives from Medicare, as well as Medicaid, were asked to participate in a national technical advisory group whose purpose was to assist in developing a common HCFA coding scheme and all related policies. The initial approach centered around the use of CPT-4 codes and terminology as the base for describing physician services. This group was also charged with the responsibility of establishing a solution to void areas of CPT-4, such as CRD codes, codes and terminology for nonphysician services, including all forms of transportation, DME, medical supplies, orthotic and prosthetics, vision care, dental and chiropractors. Reimbursement coverage and utilization policies for each of these areas was addressed and a system for maintenance procedures to establish additional new codes and policies needed.

The appropriate parties in South Carolina were then approached and we were asked to serve as a pilot State for the implementation of the HCFA coding scheme. It sould be noted here that the scope of the project includes common claim forms, common provider manuals and workshops.

The Technical Advisory Group completed their task, and this material was turned over to South Carolina Medicaid and Blue Cross-Blue Shield on March 13th. Our experience will be drawn upon to assist other States in implementation. This will be done by documenting each step taken, the problems encountered, and statistics pre and post implementation in an attempt to evaluate the use of CPT-4 and the other HCFA common coding schemes. The statistics that we will try to keep will be the level of provider participation, errors in claims filing, and other statistics that may assist in evaluating allegations that CPT-4 is inflationary. HCFA will use this data to assist in future planning for the HCFA common coding scheme. The implementation date for the common coding scheme is July 7, 1980. At this time, physicians, podiatrists, independent labs and X-rays, mental health clinics, will use a common claim form, a common provider manual, CPT-4 codes and HCFA codes as needed to supplement CPT-4.

Although the providers involved in the project will also begin using the common coding scheme on July 7th, we will announce this through a joint bulletin. Common manuals and common claim forms will be implemented as soon as possible thereafter on a phase-in basis. Joint workshops have already been scheduled for the month of June. As expected, many problems have been encountered but, so far, have not been insurmountable. A few of the problems already encountered had to do with the CPT-4 code NABSP cross reference. The Medicaid agency had done our cross reference early in 1979. Blue Cross-Blue Shield subsequently did their cross reference, so we have had to get together and come up with a common cross reference, and this is probably one of the most difficult tasks that we have had. However, it should be a little bit easier for other State agencies since documentation of this product is a deliverable product and will be available to other States.

Provider education is extremely important since CPT-4 terminology is very different from that of the NABSP terminology. Unfortunately, when the South Carolina Medical Association started pressing for CPT-4, I can understand why the physicians wanted it. However, it has been a real problem for the claims filing clerks to understand the very strict medical terminology in their CPT-4 book. We have found that persons knowledgeable in CPT-4 and in medical terminology must be readily available to assist the provider and answer any questions. Sufficient persons from each agency will be present at each workshop to assist in answering any questions.

One of the other problems that the Medicaid agency has is that the Technical Advisory Group material, including reimbursement guidelines, was presented from the Medicare standpoint. It has been necessary to closely examine each guideline and limitation to ensure that there is no conflict with the State plan or with regulations peculiar to Medicaid. We also had to examine these guidelines to ascertain systems' impact.

South Carolina has welcomed the possibilities this project presents. We hope that it will make life easier for the providers for meeting the necessary requirements. We feel that the steps we are taking will do this.

MR. BOOTH: Procedure coding is one of the many areas in which States, in general, and Medicaid State agencies in particular, are far ahead of the Medicare program. Since I have a Medicare background, I say that with some knowledge and respect. I thought I might share with you, very briefly, why this is so, not to defend it, particularly, but to explain to you where Medicare is and somewhat how it got there, so you could understand how we got ourselves in this terrible mess.

When the Medicare program was implemented in 1966, Medicare carriers were free to choose whichever coding system they liked. However, because of controls on administrative costs, there were limits to what changes Medicare carriers could make without coming in for prior approval by the then Bureau of Health Insurance of the Social Security Administration.

The first request for a procedure code change came in 1970 when the two carriers in California, Blue Shield of California and Occidental, asked to change from 1964 California relative value to 1969 California relative value because that had just been adopted by the medical association in that State. We approved that conversion, but the statisticians watched very carefully what happened during the course of that conversion and came to the conclusion, rightly or wrongly, that the change in procedure coding led to an inflation factor in the Medicare payout in California of approximately six percent. This was over and above the normal inflation that had taken place in other States that had not changed procedure coding.

The Bureau of Health Insurance said, "no more of that," and proceeded to write a regulation which said that if a carrier could prove, in advance, that a change in procedure coding would not be inflationary, then we would consider approving it. Carriers have told us -- and I'm sure they are correct -- that it is very difficult to prove, in advance, that a change in procedure coding will not be inflationary and, therefore, Medicare has found itself in the awkward situation of saying, "we're not going to approve any changes in procedure coding." Meanwhile, of course, medical practice in this country has not stood still. There are far more procedures and far different procedures now than there were in 1966; yet some of our carriers, many of our carriers, are using the same coding system, with some modifications as new procedures come along. We have tried to limit procedure coding changes to the extent possible. We have tried to limit reimbursement by such factors as an economic index, which the Congress passed in 1972 to try to break the rate on inflation. But, again, we're dealing basically with outmoded procedure coding systems. Not the least of the problems that this causes is the inability of Medicare carriers and Medicaid State agencies, or their fiscal agents, to communicate with each other. I'm sure that those of you who have adopted CPT-4 find it extremely difficult to communicate with a carrier who is reimbursing on the basis of 1964 CRVS.

Recognizing this problem, but also recognizing that Medicare reimbursement is somewhat more limited by Federal law than Medicaid reimbursement, the Health Care Financing Administration, shortly after its formation, formed a task force to identify potential integration projects. That group came up with a total of about 40 integration projects from which the then Administrator Bob Derzon chose 20. One of those was to try to find a single procedure coding system that could be used by both Medicare and Medicaid. That report came out in the spring of 1978, so you see we haven't really progressed very far. The report, itself, recommended that CPT-4 be used, but there were a number of problems, and some of those problems have been addressed in the discussion paper in the packet Mrs. Tyssowski referred to this morning. And I would again urge that those of you who feel so inclined review that paper and submit any comments you may have. It's my understanding that that paper, or a slight revision of it, will also be presented at the Medicaid Directors' Conference in May, and presuming some period of time after that for additional comments, a policy statement will be formulated by the Health Care Financing Administration.

Having given you a little of the background, I thought I might focus a little bit more on the South Carolina experiment itself.

As Mrs. Tyssowski mentioned, we have made a commitment to move toward CPT-4. That commitment is based, in part, on our being able to establish, with the help of both Blue Shield and the State of South Carolina, a reimbursement control or mechanism that reduces the likelihood that it will have an inflationary impact. If we fail in that endeavor, if we cannot do that, it is somewhat questionable whether we will move ahead with CPT-4. But we have some confidence that, with the cooperation of all the interested parties, the reimbursement mechanisms can be established so a procedure coding system can be installed and not be inflationary.

We have reviewed, as Caroline pointed out, CPT-4. We have added the codes for those services that are not in CPT-4 and that are common to both Medicare and Medicaid. We have not, in this particular experiment, dealt with drug claims, we have not dealt with drugs. We have dealt with durable medical equipment, ambulance services, and so forth. We are at the point now of approving, for use in the experiment to begin in July, the codes and terminology that will be in the manual. We expect, as Caroline indicated, to be able to implement the system in South Carolina -- again, of course, on an experimental basis - on July 7th.

The carrier and the State, at that point, will be accepting and using the codes and terminology in this coding system. There will be the opportunity to add codes to the system as Blue Shield and the State begin using the system and find out that we've forgotten a few things -- and no doubt they will. There will, of course, be a fairly continuous exchange of information, including changes in codes that have to be assigned. This will be done, hopefully limiting the reimbursement with the controls that are established or revising the controls during the period of the experiment, which will be from July 1980 through June 1981. We would then expect to evaluate the system used in South Carolina and determine whether or not it's appropriate for use elsewhere and, to the extent that it is, we would be encouraging people to adopt the system and, of course, requiring the Medicare carriers to adopt the reimbursement controls as well. We would expect that the final evaluation of the system would take place by December 1981 and thereafter be ready for implementation across the country.

As you can envision -- and perhaps just to sum up -- there are several concerns that we feel need to be resolved by the pilot. The first concern is the cost of conversion, both to the State and to the Medicare carrier. Naturally, we are also very concerned about the Federal government's share in that, the escalation or lack of escalation in program payments. And our last concern is the degree of program integration that can be obtained by using a single procedure coding system; how much integration is possible, how much is desirable. We have found extreme cooperation on the part of both Blue Shield of South Carolina and the State, and we look forward to working toward the successful culmination of this pilot.

QUESTION: I heard a lot of talk about the ICD-9 even before we had these new codings, etc., but I've never gotten a real feeling of where and when HCFA intends to go.

MR. BOOTH: What dastardly deeds is HCFA proposing with regard to ICD-9CM and CPT-4, and where will all this lead us, and what communication have you had with provider groups and others so that we are not strung out on a limb? Is that a representation of the question?

We have had extensive hours of communications and conversations with provider groups, the American Hospital Association, the American Medical Association, and others, with regard to both diagnostic and procedure coding. If the paper in the packet does nothing else, it does explain that. It has been fairly well agreed by the national representatives of these groups, and therefore HCFA has concurred and promulgated ICD-9 as the diagnostic coding system that will be used when diagnosis coding is required in any of its programs. Currently, the Medicare program does not require either providers or carriers or fiscal intermediaries to code diagnosis codes, per se. What we have said to them is, if you code, it must be ICD-9CM and it must be all five digits. Some of them are finding that a bit of a shock, but they are getting use to it.

With regard to procedure coding, it's a little more complicated, primarily because there are more different procedure coding systems than diagnostic coding systems and, second, there is some disagreement at the present time between groups like the American Medical Records Association and the American Medical Association about what kind of procedure codes are needed in what setting. Some individuals who do procedure coding for inpatient hospital services believe that CPT-4 is insufficient and inadequate. It is fairly well recognized that CPT-4 is adequate for fee for service reimbursement. The long range HCFA goal in procedure coding is to modify CPT-4 to make it acceptable for those who believe it is not acceptable now for coding inpatient hospital procedures. And we would hope that before that longer range system is promulgated, we will have the support of the American Medical Records Association and perhaps even the statisticians.

We think we know where we are going now. Obviously, as I indicated earlier, if the South Carolina experiment were to blow up in terms of reimbursement controls, we'd have to rethink that. We believe that it is possible in the relatively near future to modify CPT-4 to take care of the problems that have been voiced by the individuals who code procedures on the inpatient side. I would expect that the next draft of the paper on procedure and diagnostic coding would probably include the tentative HCFA timetable, which is undergoing final review in the Administrator's office. It has already received sign off from the appropriate bureau directors in HCFA, namely Mrs. Tyssowski of Program Operations; Mr. O'Connor of Policy; Dr. Smits of Health Standards and Quality; and, Dr. Kaple of the Office of Research, Demonstrations and Statistics.

As we lay that timetable out, I think it will become much more clear. Basically, we would intend to have the work done on the fee for service system fairly rapidly and the test in South Carolina taking place over the next year or so, with the final evaluation of that by the end of 1981. And we would hope that the longer range system will be available for implementation by the end of 1982.

QUESTION: To what extent did you take diagnostic related grouping and its reimbursement methodology into account into developing this system?

ANSWER: Our statisticians have been advised by the people who developed the DRG system at Yale that it was convertible to ICD-9 over time, and so we did not consider that that was a problem, nor did we consider that the CPT-4 would be a particular problem. So, it was kind of discussed tangentially, but it was not a major portion of the consideration. At this point, I believe New Jersey is the only place where we have given permission to go ahead with DRG reimbursements, but I would expect that there will be some other facets of that experiment coming down the pike.

USE OF MMIS FOR NATIONAL MEDICAID DATA BASE DEVELOPMENT EFFORT: PHASE ONE

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DR. DOBSON: I will now change the agenda to a research perspective. Over the past several years I have been developing, somewhat reluctantly, into a data base builder. This has resulted from my experience with the PSRO evaluation and earlier similar situations I encountered while evaluating Public Health Service programs.

While planning for the initial PSRO evaluation I found that it was necessary to take the initiative and modify the Medicare data bases that were then available in order to meet the evaluation's objectives. In the Medicaid area, this need for evaluation and research data base development is even more apparent as no data bases exist which will support national program evaluations or research related to Medicaid program beneficiaries.

Today I would like to talk about some of the Medicaid data initiatives that are under way in HCFA to support statistical reporting, research, and evaluation activities in the coming years. I am going to take a broader perspective than that indicated on the agenda, in that I will talk about the primary Medicaid research data initiatives that we have underway in the Office of Research, Demonstrations and Statistics (ORDS).

Last year I spoke before you primarily in terms of concepts. This year I am happy to report that I will be able to talk to you in terms of progress reports as well as concepts. Some of the things that I mentioned last year are now underway: surveys are in the field, contract activities are beginning, etc.

I would like, before I go any further, to thank you for the cooperation that we have received from you, particularly with our large survey, the National Medical Care Utilization and Expenditure Survey (NMCUES). We received a great deal of cooperation from California, New York, Texas, and Michigan during the developmental stages of that survey. With continued support, I think we will be able to do all the things that I am going to speak about today.

In terms of an overview, today I will discuss the purpose of Medicaid data initiatives from a reporting and analysis perspective. This purpose is in many ways quite different from the management perspectives you have been hearing this morning. I think it is useful that the research people have the opportunity to talk with you, as well as those with administrative and demonstration perspectives, because oftentimes the two groups have different data needs and thus, place slightly different demands on you.

I will then talk about the desired characteristics of Federal level Medicaid statistics from a research perspective, a slightly different perspective than what we have been hearing this morning. I will very briefly outline a research data strategy which combines administrative records and survey data and how this fits within the broader context of HCFA integrated data activities. After this, I will discuss the existing Medicaid data sources that we have considered for use in terms of Federal level reporting. I will conclude with a description of the initiatives that are currently underway.

The need for Federal level Medicaid statistics is becoming ever more apparent. During this past session with the House Appropriations Committee, it was very clear that HCFA must improve the kinds of Medicaid statistics it currently generates, the analyses it conducts, and the reports it produces for Medicaid beneficiaries. In particular, HCFA cost estimates, actuarial estimates, and program statistical reporting are all considerably better for Medicare than for Medicaid. This is a discrepancy that has not gone unnoted by those who sit on our appropriations committee, and a situation which Leonard Schaeffer wants to correct as he goes forward to the Congress during upcoming budget cycles.

Problems also exist at the staff level. Frequently, HCFA staff get Medicaid data inquiries they simply cannot answer. My Medicaid data branch chief has a standard answer to many questions concerning Medicaid, "I don't know, nobody knows, and God only knows." This is not a particularly viable situation.

In order to best administer and run the Medicaid program, we need to know answers to three basic questions: "Who does and who does not receive benefits? At what rate are various categories of Medicaid financed services used? How much do these services cost the government?" These are very much the same questions that we have dealt with this morning. They all have to do with continued emphasis on better use of our limited program dollars.

In particular, we need Medicaid data to support management and policy activities, such as the development of broad program policy formulation, long range actuarial estimates, Medicaid program planning and refined budget estimates. In terms of research and evaluation, we would like to assess cost containment, second opinion surgery, health planning, Medicaid and PSRO program activities, and the relationship between the Medicare and Medicaid programs in terms of spend down issues. We would also like to conduct special studies on beneficiary impact related to: 1) varying utilization and surgical rates across persons and areas; and, over time, 2) comparative performance across program components; and 3) diagnostic and procedural mixes. As you have heard this morning, our Medicaid diagnostic and procedural codes are quite nonuniform, almost random from the point of view of a researcher. This is an area which HCFA will attempt to unify. In particular, it will be very useful to develop consistent diagnostic codes and procedural labels across the Medicare and Medicaid programs.

We would also like to provide feedback to the States concerning comparative use rates by eligibility categories, etc. That kind of information now is essentially unavailable. Within several years we would like to be able to provide this information on a routine basis as we now do with Medicare statistics. Finally, we would like to improve our capability to assess the cost and impact of long range proposals, such as major program changes in eligibility, scope of coverage or benefit levels and in major initiatives such as National Health Insurance.

In order to articulate the desired characteristics of Federal level Medicaid statistics, I will briefly describe the basic characteristics of the existing Medicare statistical system (MSS). We have had a good deal of success over the past decade in reporting Medicare statistics. Because of this success, the MSS can provide a working model of Federal level statistical reporting, that is, the MSS can serve as a guide for the conceptual development of a Federal level statistical system. By this, I do not mean to imply that the variables or content would necessarily be the same, but that system structures might be comparable.

The characteristics of the MSS that are relevant to today's discussion are:

- Uniform data for the entire nation, permitting the comparison of beneficiary and program behavior among all regions, States, counties, etc;
- Continuous inclusion of data for all program components and beneficiaries;
- Unit record data elements which provide system flexibility to address many research questions;
- Provision of claims, provider, and enrollee data files which can be linked through the use of unique ID numbers;
- Knowledge of provider of service locations and beneficiary residence which enables production of data files at various levels of aggregation (PSRO, HSA, State and county, etc.), and permit the study of patient migration patterns (differences between the location of patient residence and the location where treatment is received);
- Inclusion of diagnostic and procedural information; and
- Availability of beneficiary demographics (age, race, sex).

These characteristics enable the MSS to support a wide variety of statistical reporting functions: to construct a variety of data bases (e.g., national, regional); to produce local, uniform, descriptive statistics; to do longitudinal, cross sectional and comparative analyses of beneficiary use and reimbursement rates; and, to develop actuarial projections and to provide answers to detailed data requests.

The primary weakness of the MSS pertains to diagnostic and procedural coding. Differences in the completeness, accuracy and nonuniformity of coding have been well documented. The problems which relate to diagnostic and procedural data are very complex and will require much attention in the future. The MSS also lacks income, employment, health status, "noncovered" service utilization measures and disposition of patients, but these omissions can be compensated for through the use of survey data and other general purpose files.

Medicaid statistics currently available at the Federal level are contained in the Medicaid Minimum Data Set (MMDS). We have worked hard to develop this system and we use it regularly. As you know, we have improved our Medicaid reporting as of this past April. The MMDS was designed to provide overall administrative statistics, and has proved to be extremely useful. However, for much statistical and analytical research, we need detailed unit record data like that described above. Since the MMDS is not in unit record format, the analytical potential of this system is limited. The nonuniformity of MMDS also poses problems. The numerous sets of eligibility categories and services provided inhibit the production of national statistics. We currently tabulate 53 different sets of aggregate statistics. The production of national Medicaid statistics from these 53 data sets is an extraordinarily difficult task. Now that we are being called to integrate not only Medicaid data across States, but Medicaid and Medicare data as well, our administrative and analytical data problems have become even more difficult.

Our initial efforts at collecting uniform unit records which meet HCFA's Medicaid research needs will, by necessity, be limited. For example, for short stay hospitals a basic linkage of eligibility data to utilization data could produce average length of stay, admission rates per 1000 Medicaid beneficiaries in short stay hospitals. By adding diagnoses and procedures to this information, analyses related to diagnostic mixes and surgical rates can be developed. The inclusion of reimbursement information enables analysis of program expenditures either on a per case or per day basis. From these data we could determine how many dollars were spent, what they purchased, who benefited and where services were received.

All in all, compared to the Medicaid Management Information System (MMIS) data sets that you work with, I think this is a fairly simple data set, yet a powerful one. During the initial development of a Federal level research data base, I would like to do a few things well, rather than attempt to accomplish everything at once.

In order to develop a research oriented data base that will also serve administrative reporting needs, a variety of activities must take place. First, design objectives similar to those presented above need to be established. Then a "hands on analysis" of existing data bases must be conducted in order to determine what actually needs to be accomplished in order that research demands and administrative needs can be simultaneously met.

In the broadest sense, the ORDS' Medicaid data initiatives will combine administrative and survey statistics. Administrative records will provide unit records of users containing basic use and reimbursement data for covered services. Administrative claims data are particularly useful because they can be obtained rapidly and inexpensively through existing statistical systems for all beneficaries. Survey statistics, on the other hand, have a slightly different bent. They provide data for both beneficiaries and nonbeneficiaries. This is an important addition to our information base in that it enables comparisons between beneficiaries and nonbeneficiaries. This is particularly useful for proposals to expand program coverage. Surveys also provide more complete user demographics including such items as income and employment that are not otherwise available for the Medicaid population. And, as you well know, in any kind of analysis related to Medicaid beneficiaries, it is helpful to have income and employment data. Health status data can be developed through surveys as well. Finally, surveys can provide reimbursement and utilization statistics for both covered and noncovered services along with relevant payment sources. Information on out of pocket expenditures is, of course, extraordinarily useful when conducting analyses of program impact. The major difficulties with survey data are expense and lack of timeliness. Therefore, a judicious mix of administrative data and survey data is required.

One final point in terms of strategy is that the ORDS' Medicaid data activities will take place within the context of HCFA's integrated data activities. These activities will strengthen our efforts considerably.

Before continuing, I would like to discuss the notion of data integration. It is a concept that all of us will be forced to deal with in the near future. Unfortunately, it means something a bit different to just about everybody who considers it. The notion of integrated data, at the most micro level, concerns the linking of billing and medical records data. We currently do this in the Medicare program with our 1453 billing form. The UB-16 is another example of an integrated data set. Uniform diagnostic and procedural coding systems are being developed to facilitate this effort. Another form of integration that I have referred to already is the linking of the billing and medical record information with eligibility data to calculate utilization rates. An even broader notion of data integration relates to linking uniform claims and uniform codes (uniform everything, if you will) across the Medicare, Medicaid and PSRO programs. At the broadest level, it includes the linkage of a variety of data, including the Annual Hospital Report (AHR), with the claims and other data to create a complete file of information. Other projects at HCFA are underway in these areas. Eventually private payors might be included as well. The ultimate integration would find all users working with essentially the same data sets which could be processed by central processors. As you can see, efforts to improve Medicaid research data are just a part of the overall HCFA data strategy.

There are a variety of data sources which we could use as a basis for the development of a Federal level Medicaid research and administrative data base. Today I will discuss MMDS, MMIS, PSRO Hospital Discharge Data Set (PHDDS), the Medicaid Quality Control System (MQCS) and the Health Interview Survey (HIS) and indicate the degree to which we will use these data sources as we develop improved Federal level statistical systems for the Medicaid program.

Medicaid Minimum Data Set (MMDS): The MMDS, which I was just discussing, represents an improvement on existing Federal level Medicaid statistics. The monthly 120's were implemented April 1, 1980. The annual 2082's will be implemented on October 1, 1980. The most important new elements in the MMDS from a research perspective are the provisional counts of eligibles. With eligibles' counts we can start to get some notion of expenditure flows and utilization rates associated with the various types of populations at risk, e.g., SSI, AFDC, etc.

There are also sections on provider participation and EPSDT that are still in the developmental stages. Our sterilization and abortion special reports continue and are widely used. We probably get as many requests on the sterilization and abortion activity as we do for all the other Medicaid data put together. While these reports are difficult for you to produce, I assure you that the Department and the Hill follow and monitor those reports very carefully.

While the MMDS data are an extremely useful source of aggregate statistics, they do not provide person based statistics required to support actuarial projections, development of use rates or allow flexible data manipulation. That is, they do not allow for the cross tabulation of numerous variables, one against the other, or for the application of multivariate statistical techniques. Thus, our research data base must ultimately be based on another data system.

Medicaid Management Information System (MMIS): The MMIS is unique in terms of unit record data, but it is not available at the national level and its data is somewhat inconsistently developed from State to State. Researchers who have tried to link State MMIS data files together have had a great deal of difficulty. In fact, I do not know of one single research activity where numerous State MMIS data have been successfully linked to create a research data base. Experiences such as these suggest that we should attempt to develop a fairly simple national data base to start with. We might use the key variables I mentioned above in the short stay hospital area and comparable variables in other areas. We will soon be developing prototypes of such systems to demonstrate the feasibility of various approaches to the construction of a Federal level unit record data base.

The volume of MMIS data is also a problem. We estimate - and I do not know how close this estimate is - that there are something like 15,000 reels of MMIS data tape generated each year. Clearly, with staff numbering in the tens and twenties, 15,000 reels of tape would innundate us. We will have to figure out how to sample from your files.

The biggest problem with MMIS, which we heard about this morning from New York, is difficulty with the eligibles' counts. The reason these counts are so important is that they provide information related to the population at risk. Without this information, use rates cannot be calculated for beneficiary types. That is the big weakness for PSRO and other evaluation activities. If we have no real notion of what change in use rates are associated with a given program activity, it is difficult to explore the impact that our programs have on beneficiaries. Despite the problems associated with MMIS, this is clearly a data base that will be explored as we develop our Federal reporting system.

The PSRO Management Information System (PMIS): The PHDDS is a useful data set because it contains information on both Medicare and Medicaid beneficiaries and diagnostic and procedural information.

However, PHDDS is limited to active PSRO areas and it covers hospitals only after the PSRO review has been initiated. In addition, the linkage of eligibility and claims data is essentially impossible because the system does not contain a system of ID numbers. Given the resources on hand, we do not plan to use PHDDS in our initial effort to develop a Medicaid research data base.

Medicaid Quality Control System Data Base (MQCS): MQCS represents an existing data base of manageable proportions. Because of this we hope to be able to get some answers from it in a relatively short time span.

MQCS is a joint venture of the Bureau of Quality Control (BQC) in HCFA, the HCFA regional offices and the States. MQCS is operated within every State Medicaid agency to monitor and improve the administration of its Medicaid program. While the purpose of MQC is a quality control system for detecting errors in eligibility, unrecovered third party liability insurance payments, and claims processing errors, we plan to use the data for other purposes.

The survey contains about 150,000 cases annually. The unit of observation is the Medicaid case, not necessarily the individual. Each State selects a sample, representative of Medicaid cases within that State. The 1634 States have slightly different sampling strata from the non 1634 States. Data is collected on about one month's health care utilization experience. The procedures include a field investigation to document eligibility and third party insurance and claims processing review on all paid claims which occurred during the review month for the sample.

Health Interview Survey (HIS): The final source of data I will discuss is the Health Interview Survey, conducted by the National Center for Health Statistics (NCHS). I bring this up primarily because the Health Interview Survey has been conducted for some number of years, and surveys, as I mentioned above, can be used to complement administrative records. The Health Interview Survey, however, does not allow for small area estimates. This means that we cannot say very much about Medicaid populations in any given State. This is a critical limitation for a State administered program. To avoid these problems HCFA and NCHS have jointly developed another survey, the National Medical Care Utilization and Expenditure Survey. I will discuss this survey when I describe our current Medicaid data initiatives.

ORDS Medicaid Data Initiatives Related to Research Activities: Given the available Medicaid data sources and the data strategies outlined above, ORDS is undertaking the following Medicaid data initiatives: 1) MMIS data acquisition from selected States for the development of Medicaid utilization rates and descriptive and administrative statistics; 2) survey activities in the form of the National Medical Care Utilization and Expenditure Survey (NMCUES) and a Survey of Institutionalized Individuals (SII); and, 3) an exploration of the potential utilization of MQCS for descriptive statistics and administrative purposes.

State MMIS Data: The purpose of this effort is to develop a prototype person based Federal level Medicaid data set based on MMIS records. The system will consist of a unit record claims file, an eligibility file, and a provider file. Unit record identifiers will be used to the extent possible to facilitate file linkages. The anticipated statistics will support the production of baseline descriptive data, analytical and evaluation studies, and special studies related to policy and management. As I have said before, we will try to keep the system fairly simple. The example I gave for the short stay hospital sector (date of admission, date of discharge, aggregated diagnostic and procedural codes when available) is about the level which we feel is feasible. This level will support a great deal of reporting and analyses.

The key advantage of State MMIS data is that unit record claims are potentially available. As we have heard this morning, we are doing much better across the country now at processing MMIS claims. We have talked to a lot of States and feel that MMIS unit record claims data can now be integrated across States. The real problem is, however, that eligibility counts must be refined. I think that is the downside of what I have to say today. The eligibility count issue is extraordinarily difficult for a lot of reasons and numerous approaches to the problem have been identified. The population at risk (eligibles) can be determined by counting all beneficiaries at a given point in time, viewing a particular cohort group and tracking it across time, or by counting only those beneficiaries that have been in the program for some fixed period of time, e.g., three months.

Even more basic is the problem of defining eligibles. Are eligibles card holders or people who could have a card? Or are beneficiaries those who have used the program within the past year, etc.?

The only work that I have seen that successfully develops Medicaid utilization rates for evaluative purposes is the Brook, New Mexico study. He steps down from inclusive counts of eligibility to delineating well defined cohort groups. These cohort groups are identified for a specific starting period, and are tracked through time to determine their health care utilization characteristics. We will build on all prior research efforts and attempt numerous solutions when we address problems related to eligibility counts.

We will also need to understand the differences in State programs. As you can well appreciate, the various notions of eligibility, varying coverage and benefit levels and other program variations across States will ensure that data comparability is difficult to attain. Similarly, we will also have to be sensitive to local concerns with the usage and interpretation of the data. Confidentiality issues will likewise be a problem. We will continue to work to gain your cooperation as we try to solve these kinds of problems.

In terms of anticipated activities, we have written an RFP which will be released this summer. The scope of work has three phases. The first phase, running some six months, is a planning and developmental phase. It involves designing a research plan, gathering background data from several States, evaluating data consistency and quality over time, developing uniform data formats and completing exploratory analyses. Four to six MMIS files will be selected for continued analysis. Eventually, four States' MMIS systems will be entered into the prototype system.

Phase two, which will last some twelve months, involves data acquisition and analysis. We will finalize the analysis plan developed in the first six months, and obtain 1979 claims, eligibility and provider data from the selected States.

We will create uniform data records for defined units of service on a sample basis. I suspect that the drug claims from New York and California alone could absorb all of our resources for a couple of years if we attempted to construct 100 percent files. We will obviously have to take very small samples from the larger data files and from the larger States. Phase II will conclude with the generation of basic descriptive analyses and table generation, the development of actuarial techniques, the preparation of introductory analyses concerning PSRO impact upon Medicaid beneficiary utilization, the creation of data books for contributing States, and the reporting of analytical and methodological findings after the end of the first year.

Phase III, which will be initiated about a year and a half from now, will expand the initial data base and related analyses. In particular, we will obtain 1980 data for the original group of approximately four States, and obtain 1980 data for an additional number of States.

After two years, we will have, at best, eight to ten States, but I think that would be a large contribution towards understanding what the Medicaid program does. If we are able to select some of the larger States, we can account for a large proportion of Medicaid dollars as well.

Phase III will continue to refine descriptive analyses and provide data to support actuarial projections. Our actuaries are very interested in this project and hope that it will eventually help them do their job better. Finally, we will prepare recommendations for future development of a uniform Federal level Medicaid statistical system. That is to say, the eventual idea is to implement the prototype system across all States.

As MMIS comes into place and as our data processing capabilities are improved, it should be possible to acquire records that will be useful at the Federal level. Once these data are reported on computer tapes we can deal with it at the Federal level, reducing the burden on States.

National Medical Care Utilization and Expenditure Survey (NMCUES): Many of you are probably already involved with NMCUES as Leonard Schaeffer has recently signed a letter which has gone to numerous Medicaid administrators asking for their cooperation. I expect that in many instances this means your cooperation, because you are the people who will eventually help us get what we need. NMCUES is jointly sponsored by HCFA and NCHS. Its purpose is to collect and analyze data on health care utilization and related expenditures (including out of pocket expenditures), access to health care, health status and conditions, health insurance coverage (private, Medicare and Medicaid), and the demographic characteristics of health system users. These data will be collected for both Federal beneficiaries and private pay patients alike.

The survey will collect data from a nationally representative sample of 6,000 households and from over 1000 Medicaid eligibles selected from the Medicaid eligibility files in each of four States. The Medicaid survey component of NMCUES will total over 4,000 households, representing the Medicaid programs in Texas, California, New York and Michigan. NMCUES will be supplemented with an administrative records survey which will match administrative claims file data with NMCUES survey data. This matching has two purposes: 1) to add to the survey data base in terms of Medicaid charges and reimbursements; and, 2) to get some check on the utilization data reported.

NMCUES is a panel survey where we collect data on the same population concerning 1980. There will be five rounds of data collection during 1980, three personal interviews and two by telephone.

The NMCUES instrument is reasonably lengthy. I have observed interviews which have taken as long as two and one half hours. I was surprised to see the cooperation we are getting from NMCUES sample households. Their interest and general enthusiasm is extremely high.

We are using a summary and a diary to improve recall of past events. The diary is essentially a calendar we leave with the household. The respondents annotate the calendar when utilization is experienced and charges are incurred. The summary is more complicated as it is a computer printout that summarizes a previous round of interviews. Summaries are mailed to households between interview rounds. This enables households to review previous answers and to fill in any omissions.

We have received a great deal of cooperation from the States in supplying their eligibility files and we are very grateful. When we first started the Medicaid aspects of NMCUES, there was some question of whether it could be done. We were determined, however, to acquire data representing Medicaid populations that was otherwise unavailable. So far it looks as if we will be able to do just that.

We have constructed our samples and were in the field on schedule (February 4, 1980). We are now nearly finished with our first round of data collection, and it is going pretty well. It appears that our response rates will be adequate. The one problem we are having is that in the four State Medicaid Household Surveys, many of the addresses we receive from the eligibility files are not current. Fortunately, we oversampled so we will still achieve the required number of completed interviews.

Our second round of interviewing will be starting soon. We expect the first six months of data by the end of 1981, that is, if all goes well. We expect our final data tape by 1983. We will use the six months tapes to provide preliminary data and to develop preliminary NMCUES data file structures. We are currently developing analytical and publication plans.

The Survey of Institutionalized Persons (SII): SII which is currently in the developmental stage will collect data representing institutional populations and providers. Current sample plans call for 10,000 residents in 1,250 institutions. The methodological problems in an institutional setting are quite different from those encountered in NMCUES. SII will have to deal with people who cannot respond for themselves and use institutional and accounting records that are difficult to interpret uniformly. Also, we will have to determine how to track services received from outside of the institutional setting, e.g., physician services. In addition, we will want to link residents to the households from which they came and to which they might return. The first year or so of SII's development will focus on resolving problems of this nature.

SII analyses will ultimately have a decided Medicaid emphasis, because such a high proportion of institutional residents are Medicaid beneficiaries. We will eventually combine SII results with NMCUES and our Medicaid and Medicare administrative records. Field work is currently scheduled for 1984, and even at that, it is a fairly tight deadline as we try to work our way through the problems that we will encounter. The developmental effort will be initiated this fall.

The Medicaid Quality Control System (MQCS): The MQCS combines features of both a household based survey and administrative records. Verification of eligibility and third party insurance coverage occurs during a household interview, while the claims processing review is accomplished by caseworkers working with records from the State's file. We have issued an RFP which should be "on the street" shortly. The purpose of the RFP is to utilize the person/case based data already contained within the MQCS for Medicaid analyses. The first stage of the contract will be to actually construct a preliminary national Medicaid data base from six months of MQCS data and to produce reports from this data. The possibilities of using the data for actuarial and evaluation activities and the existence of possible linkages to other data bases will also be explored. Results from this preliminary stage and subsequent recommendations will be used to construct an annual data base beginning with data from 1979. The advantages of using the MQCS data for Medicaid research are that: 1) the data are uniform across States; 2) every State Medicaid Agency participates; 3) the entire Medicaid population, including those in "State only" programs, is represented; 4) the information is timely; 5) both national and State estimates can be made; and, 6) person based data on eligibility and utilization is available.

In summary, we have a fair number of Medicaid data initiatives underway. We are looking at administrative records and we are looking at survey data. In the long run, we hope that all of these activities will fit into the context of the broader HCFA integrated data activities.

Questions and Answers

QUESTION: What will we do with MMDS while we are working on all the other activities?

ANSWER: We do not foresee any changes to MMDS at the current time.

QUESTION: What can we do to simplify the eligibility categories when we try to do projections and rate analyses?

ANSWER: We have thought about that at length. The problem is that the basic Medicaid eligibility categories are probably very different in terms of their actuarial utilization and demographic characteristics. At a minimum we will have to sort out the basic eligibility categories and conduct separate analyses on each category.

On NMCUES, for instance, we noted that with 1,000 households per State and four Medicaid eligibility categories, "cell sizes" would be rather small at 250 households per category. As any more categories would bring about unacceptably small cell sizes, we arbitrarily limited the number of categories to four. As a consequence, we went through our sample frame and put each of our sample households into one of those four categories. In this sense, we did exactly what you have suggested. We limited our categories to four because of cell size constraint and allocated our sample accordingly. I suspect that age, race, sex, and other breakdowns will fall out naturally enough once the study analysis begins. The real issue, as I see it, is not so much the selection of eligibility categories, but the handling of movement in and out of the program. We do not know the extent to which beneficiaries who stay in the program for, say, three months are like those who remain in the program for a day, a week, a month, two years, or whatever. This is a problem we will certainly have to deal with.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT): MICHIGAN'S APPROACH

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MS. KOWALSKI: After I was told I would be speaking here today, I got back to my office, and somebody had left me a copy of Erma Bombeck's speech, where she just recently took a survey and said that speaking before a group was the number one fear among adults; that anxiety of standing before an audience beat out the fear of death, the fear of failing, the fear of height, and the fear of alienation. And she went on to give me some suggestions, and I think they are quite useful, since they are different than any I have come across before. You are supposed to demand a podium that is capable of supporting a dead body. Then throw yourself over it, and be sure you hook your arm over the microphone so you don't slip away. Number two, I am supposed to adhere to the old wives' tale. "Feed a cold crowd and starve a speaker." I think the reason for that is obvious. Also, I am supposed to insist on a table near the rest room. For some unexplained reason, speakers have a kidney wish. And I think one of the best ones is, never read your speech. Use note cards, which serve a double purpose. You can rearrange them to fit your audience, and in the event the person who introduces you uses the jokes on your first card, you can use the sharp cutting edges on your wrists. I have sharpened my cutting edges.

Let's start with a little background of Michigan and EPSDT. In 1972, HEW issued the final regulations mandating an EPSDT system, and Michigan complied by implementing the required system. Since its inception, an average of 9,000 children and youth under 21 have received health assessments each month. That system seemed to be sufficient for the screening and outreach efforts, but with a referral rate of approximately 58 percent, we realized that we were missing a very important segment of that system: what happened to those children and youth after their health assessment or after their referral. Then, in 1976, Michigan was informed that HEW had contracted with Consultec, Incorporated to design a model EPSDT/MIS system. The reporting concept sounded like the answer to our problems, and we awaited final approval from HEW. However, that approval was never issued. As Michigan has always strived to be a leader in the health care field, we were mandated to design a model system of our own.

The responsibilities for the EPSDT system fall into two departments within the State. The Department of Social Services has a contractual agreement with the Department of Public Health. The Department of Social Services is responsible for the outreach efforts including: contacting the eligibles; scheduling appointments; rescheduling noshows; transportation, if necessary; and, the recording of the refusals.

The Department of Public Health is responsible for the health screening, scheduling appointments for referrals, and any followup investigations.

The EPSDT management information system is comprised of five major components or modules. These modules are: 1) outreach; 2) screening; 3) treatment; 4) followup; and, 5) case management. These modules fit together to form a data base for EPSDT recipients. This data base is designed with the recipient I.D. number as the key, and allows the EPSDT history to be maintained per client. Eligible clients are determined from our Client Information System each month. Eligible clients are compared with the EPSDT history file to determine recipients needing to be contacted through outreach efforts for the month.

There are three primary documents that are produced at that time, which include: 1) a letter to the recipient explaining EPSDT and an indication, if they are interested, to contact their case worker; 2) a Case Status Summary sheet, which is computer generated with recipient identification information, produced as an internal case management tool for the county outreach workers; and, 3) the listing of eligibles, which serves as a master listing of all recipients per month needing outreach efforts. Receiving the Case Status Summary sheet and the listing of eligibles, the county outreach office begins the process of contacting the recipients and trying to arrange a screening appointment. If the recipient refuses screening, or is contacted and scheduled for screening, a refusal form is completed and loaded to the data file. If the client accepts screening, an appointment is made with the screening clinic. It could either be the health department, the contracted agency, or an enrolled health provider. If the client does not show for the appointment, outreach activities begin again, with further contacts. Assuming the client does make the arranged appointment, a health screening is performed. And resulting from all health screenings is a Medicaid Screening Summary, which primarily gives the health characteristics of the child screened. This form is forwarded to the State for encoding of the screening information.

If a referral is made because of a health condition detected at the time of screening, the referral information is added to the Screening Summary form. The referral information includes: the provider's name; the provider I.D.; his/her type; the condition for which the child was referred; and, the appointment date. When referral information is received by the State, a file is prepared in order to match against a Medicaid invoice. When there is a match between referral and invcice, the data on the invoice, such as the diagnosis, the procedures billed, the service date, the amount charged and the amount paid, are reported. If a match does not occur within 120 days, a referral update form is system generated and forwarded to the county followup workers. The form, in essence, identifies recipients for whom the State has screening and referral information, but has not received any treatment data. We are requesting that the followup worker investigate the case and report any findings. The county followup worker's response is on the same referral update form, which is a turnaround document, and gives the data on the reason for no invoice. For example, the recipient might not have gone to Dr. Jones, but, rather, went to Dr. Smith. And this additional information will allow us to make the appropriate connection in the system. We felt that it was best to use the Medicaid invoice as our data capturing mechanism because we know that the providers are going to bill for their services.

We also spent considerable time in our forms design efforts. We had several considerations. There was a lot of duplicate information on various forms, and we didn't want to have the county people spending all their time filling out forms. It had to be easy to use, and it had to be especially easy for key encoding. With the previous screening summary forms that were used, the key encoders got paid premium rates for keying them. They were that difficult. I think we resolved this issue by the use of a carbon snapouts and shading in various areas of our forms.

Various forms that we have used are in the Appendix. One is the refusal notice. This is the form that is used in the outreach office when a recipient has either not showed for an appointment a number of times, or has just refused to accept any of the services. We have used a little gimmick on this form that would save the county people some work by using linetype option, and that's the field on the far left hand side of the form. They can either list a case number or an individual recipient I.D. number. If all the recipients in a family refuse screening, then they can just list the case number for that family instead of each individual I.D. number and name.

The shaded areas on the forms are the areas that are designated as unnecessary for key encoding. The key encoders do not have to pick up the fields that are shaded. So, they will know without looking all over the page, without having to refer back to their instructions, which areas they do have to pick up.

Another form is the Medicaid Screening Summary, which is a three part carbon snapout. The first page is the screening summary itself, and the second page of this form is a copy of the Medicaid Screening Summary. The third page is the referral outcome, which is a completely different form. The way they have done that is, between the first and second sheets of paper, there is a complete page of carbon that allows you to transfer all the information onto the copy to be stored in the clinic file. And then there is about a quarter of a sheet of carbon that takes you down just through the referral data information, so that all the recipient demographic information will copy onto the referral outcome form and the county workers don't have to duplicate their efforts in recording all of that information. The referral outcome form was designed primarily to be used for referrals that were made to non-Medicaid providers. Especially in the immunization area, a lot of recipients are referred to a public health clinic or their school for the immunizations that are needed. When the clinic had information readily available as to the results of that referral, they were to be recorded on this form and sent back in. However, the county workers are finding that they have a lot of information at the time they are ready to send this form back in, not only for non-Medicaid providers, but also for the regular Medicaid providers, so they are using this form for a dual purpose. The referral update form is the next one, and this is a turnaround document. It's computer generated with the recipient name, I.D. number, all of his demographic information. And on the lines below that, the system will print the information that came in on the screening summary as to the reasons for referral. It will give the provider's name that the recipient was referred to, I.D. number, provider type, and what the referred condition was. All the county worker would have to do is to fill our the referral outcome box, which is a one digit field, and the legend is down at the bottom of that form. The last form is the case summary report, and this is the one that is generated in one of our first processes each month. This is an inhouse document for the county workers. It does not come back into the system. It is computer printed with all the recipient information on it. It will show the last screening date, any previous appointment dates; if he/she didn't show, why he/she didn't show the last time; and, a section at the bottom to indicate if transportation was requested, if they used the transportation, and if they asked for day care. This is kept in the files at the county level.

The worker reaction to our new system so far has been quite good. They are very pleased with the information they are getting. They are getting more management information than they ever have before. We are asking them to supply us with a lot more information than they have ever had to before, and we felt that they would probably kick a little about that, but I think when they are able to see the results of their efforts in reports that assist them in their job, it makes it easier for them to handle.

We have approximately 24 different output reports. They are primarily Statewide comparative summaries of segments of the health assessments. I am sure most of you are aware that with any new system, there are always problems that you will encounter, but this system went quite smoothly, really. Our biggest problem, however, happened to be the new Federal regulations that came out. It wasn't so much the regulations themselves, but the timing of them. We had our system almost totally designed when the new regulations were finally issued. In most areas we were doing what the regulations stated, but in some cases, it would be difficult to support for audit purposes as there wasn't any standardized documentation. For example, in the transportation area, we record that the service was provided, but did not document the date it was provided. In the regulations, it requests the date that it was provided. The regulations necessitated adding a few data fields to our forms. The portion of the regulation dealing with dental referrals is a big problem for us. I think the stance that HEW took in this area amplifies the need for greater State participation in the development of these regulations. The number of referrals that will be generated from the requirement far outweigh the number of participating dentists that we have in the State. And, in fact, in some of our smaller counties, we conducted a survey, and it came out to be a ratio of about 160 EPSDT recipients to one provider per month, and they just can't handle that. We are meeting with the Dental Association to try to generate some greater participation in this area, but that is a way down the road. We are more or less in a position, at the present time, where expending the time and effort to put us in compliance in the dental area is more costly than accepting the penalty.

Overall we are very pleased with our new system. It's efficient, and it tracks the recipient through the entire process from initial contact to treatment. It provides management reports. And, most importantly, it allows us to monitor and ensure that appropriate health care is provided for those recipients we are charged with serving. (Michigan's EPSDT forms follow.)

MEDICAID SCREENING SUMMARY

Michigan Department of Social Services
Michigan Department of Public Health

1. Claim Reference Number

DO NOT WRITE IN THIS SPACE

2. Agency Name		3. Agency ID Number	4. Agency Type	5. Clinic Number	**6. Locator Code**	
7. Recipient Name	8. Recipient ID. No.	**9. Sex**	**10. Descent Cd.**	**11. Birth Date**	12. Screening Date	No. of Screenings 13. First 14. Multi

REFERRAL DATA Do Not Type Below This Line

Provider Name	Provider ID	Prov. Type	Serv. Type	Referred Test Code(s)			Appointment Date
15	16	17	18	19	20	21	22
23	24	25	26	27	28	29	30
31	32	33	34	35	36	37	38
39	40	41	42	43	44	45	46

SCREENING DATA

	Test Code
47 Height (Inches & Qtrs.)	048
49 Weight (Lbs. & Qtrs.)	050
<5% Wt/Ht/Age >95% 51 52	053
54 Head Circ (In. & Qtrs.)	055
Blood Pressure 56 57	058
59 Other A	060
61 Other B	062
63 Hematocrit	064
65 EP 66 Lead	067
Urine 68 Sugar	069
Urine 70 Albumin	071
Tuberculosis	072
Sickle Cell	073
Vision Acuity	074
Vision Muscle	075
Vision + Lens	076

PHYSICAL INSPECTION	Test Code
Cranium/Face	077
Hair/Scalp	078
Ears	079
Eyes	080
Nose/Throat	081
Mouth	082
Teeth	083
Neck	084
Skin	085
Chest/Back	086
Abdomen	087
Genitalia	088
Muscle Tone	089
Arms/Legs	090
Hands/Feet	091
General Health	092

Hearing — Test Code 093

Hearing Threshold
094 R 095 096
097 L 098 099 100

Health History — Test Code 101
Birth Wt. (Lbs & Oz.) 102

Diphtheria	Tetanus	Pertussis	Polio
103	104	105	106

Rubella	Rubeola	Mumps	Clinic Given
107	108	109	110

DDST (insert proper test code)

Personal/Social	Fine Motor Adaptive	Language	Gross Motor
111	112	113	114

Descent
1 - White
2 - Black
3 - Am. Indian
4 - Spanish Speaking
5 - Other

Test Code Legend
0 = Required Test Not Done
1 = Tested
2 = Under Care
3 = Referred

PROVIDER TYPE CODES

Non Medicaid
01 = Psy/Soc.
02 = OP Clinic
03 = Int. Sch. Dist.
04 = Other

Medicaid
10 = MD
11 = DO
12 = Dentist

Local DPH
05 = Clinic
06 = PHN
07 = Tech
08 = CC
09 = Other

Service Type Codes
1 = Nutri
2 = H/Ed
3 = Chron Disab
4 = Other

Remarks

Screening Nurse Signature

DSS-558 (4-79)

Sign and Mail to MDSS

REFERRAL OUTCOME

Michigan Department of Social Services
Michigan Department of Public Health

1. Claim Reference Number

DO NOT WRITE IN THIS SPACE

2. Agency Name	3. Agency ID Number	4. Agency Type	5. Clinic Number	6. Locator Code

7. Recipient Name	8. Recipient ID No.	9. Sex	10. Descent Cd.	11. Birth Date	12. Screening Date	No. of Screenings 13. First	14. Multi

REFERRAL DATA Do Not Type Below This Line

Provider Name	Provider ID	Prov. Type	Serv. Type	Referred Test Code(s)			Appointment Date
15	16	17	18	19	20	21	22
23	24	25	26	27	28	29	30
31	32	33	34	35	36	37	38
39	40	41	42	43	44	45	46

Line No.	Provider Name	Provider ID	Provider Type Code	Referred Test Code	Appointment Date	Referral Outcome Code
01	47	48	49	50	51	52
02	53	54	55	56	57	58
03	59	60	61	62	63	64
04	65	66	67	68	69	70
05	71	72	73	74	75	76
06	77	78	79	80	81	82
07	83	84	85	86	87	88
08	89	90	91	92	93	94
09	95	96	97	98	99	100
10	101	102	103	104	105	106
11	107	108	109	110	111	112
12	113	114	115	116	117	118

Descent
1 - White
2 - Black
3 - Am. Indian
4 - Spanish Speaking
5 - Other

PROVIDER TYPE CODES

Non Medicaid
01 = Psy/Soc.
02 = OP Clinic
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Medicaid
10 = MD
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Local DPH
05 = Clinic
06 = PHN
07 = Tech
08 = CC
09 = Other

Service Type Codes
1 = Nutri
2 = H/Ed
3 = Chron. Disab.
4 = Other

TEST CODES

048 = Height
050 = Weight
053 = Weight/Height
055 = Head Circumference
058 = Blood Pressure
060 = Other A
062 = Other B
064 = Hematocrit
067 = Lead 01 = Macro
Urine:
069 = Sugar
071 = Albumin

072 = TB
073 = Sickle Cell
Vision
074 = Acuity
075 = Muscle
076 = Lens

077 = Cranium & Face
078 = Hair/Scalp
079 = Ears
080 = Eyes
081 = Nose/Throat
082 = Mouth
083 = Teeth
084 = Neck
085 = Skin
086 = Chest/Back
087 = Abdomen
088 = Genitalia
089 = Muscle Tone
090 = Arms/Legs
091 = Hands/Feet
092 = General Health Dev.
093 = Hearing
100 = Hearing (Threshold)
101 = Health History
103 = Diphtheria
104 = Tetanus
105 = Pertussis
106 = Polio
107 = Rubella
108 = Rubeola
109 = Mumps
111 = Personal Social
112 = Fine Motor Adaptive
113 = Language
114 = Gross Motor

REFERRAL OUTCOME CODES

1 = Condition Receiving Treatment
2 = Condition Needs No Treatment
3 = Condition Not Confirmed, Needs Further Testing
4 = Provider Not Available
5 = Unable to Locate
6 = Moved From Area
7 = Declined Diagnosis Treatment
8 = Information Not Available
9 = Other: (Specify)

DSS-558 (4-79)

Sign and Mail to MDSS

REFERRAL UPDATE (EPSDT)

Michigan Department of Social Services
Michigan Department of Public Health

		1. Claim Reference Number DO NOT WRITE IN THIS SPACE	
2. Agency Name		3. Agency ID Number	4. Clinic Number
5. Recipient Name	6. Recipient ID Number	7. Date of Update	8. Screening Date

PRINT CORRECTIONS FOR ANY INFORMATION ON BLANK LINES BELOW

Line No.	Provider Name	Provider ID	Prov. Type Code	Referred Test Code	Appointment Date	Ref. Outcome	Pre-Print
01	9	10	11	12	13	14	15
02	16	17	18	19	20	21	22
03	23	24	25	26	27	28	29
04	30	31	32	33	34	35	36
05	37	38	39	40	41	42	43
06	44	45	46	47	48	49	50
07	51	52	53	54	55	56	57
08	58	59	60	61	62	63	64
09	65	66	67	68	69	70	71
10	72	73	74	75	76	77	78
11	79	80	81	82	83	84	85
12	86	87	88	89	90	91	92

Descent
1 - White
2 - Black
3 - Am. Indian
4 - Spanish Speaking
5 - Other

PROVIDER TYPE CODES

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Medicaid
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12 = Dentist

Local DPH
05 = Clinic
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07 = Tech
08 = CC
09 = Other

TEST CODES

048 = Height
050 = Weight
053 = Weight/Height
055 = Head Circumference
058 = Blood Pressure
060 = Other A
062 = Other B
064 = Hematocrit
067 = Lead 01 = Micro
Urine
069 = Sugar
071 = Albumin
072 = TB
073 = Sickle Cell
Vision
074 = Acuity
075 = Muscle
076 = Lens
077 = Cranium & Face
078 = Hair/Scalp
079 = Ears
080 = Eyes
081 = Nose/Throat
082 = Mouth
083 = Teeth
084 = Neck
085 = Skin
086 = Chest/Back
087 = Abdomen
088 = Genitalia
089 = Muscle Tone
090 = Arms/Legs
091 = Hands/Feet
092 = General Health Dev.
093 = Hearing
100 = Hearing (Threshold)
101 = Health History
103 = Diphtheria
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106 = Polio
107 = Rubella
108 = Rubeola
109 = Mumps
111 = Personal Social
112 = Fine Motor Adaptive
113 = Language
114 = Gross Motor

REFERRAL OUTCOME CODES

1 = Condition Receiving Treatment
2 = Condition Needs No Treatment
3 = Condition Not Confirmed, Needs Further Testing
4 = Provider Not Available
5 = Unable to Locate
6 = Moved From Area
7 = Declined Diagnosis Treatment
8 = Information Not Available
9 = Other: (Specify)

REFUSAL NOTICE (EPSDT)

Michigan Department of Social Services
Michigan Department of Public Health

1. Claim Reference Number
DO NOT WRITE IN THIS SPACE

2. Agency Name

3. County

4. DPH Agency No. 0 0 0

5. Clinic No.

Line No.	Line Type	Recipient/Case No.	Recipient/Grantee Name	Refusal Code	Refusal Date
01	6	7	8	9	10
02	11	12	13	14	15
03	16	17	18	19	20
04	21	22	23	24	25
05	26	27	28	29	30
06	31	32	33	34	35
07	36	37	38	39	40
08	41	42	43	44	45
09	46	47	48	49	50
10	51	52	53	54	55
11	56	57	58	59	60
12	61	62	63	64	65
13	66	67	68	69	70
14	71	72	73	74	75

Remarks:

LINE TYPE

1 = Case
2 = Recipient

REFUSAL CODES

01 = Own Doctor
02 = Child Healthy
03 = Recently Screened
04 = Not Interested
05 = MA Closed-Ineligible
06 = In a Health Program
07 = Cannot Locate
08 = Out of Area
09 = Reason Not Known
10 = Repeated No Show
11 = Other (define in Remarks Section)

Contact Worker Signature

DSS-541 (4-79)

File

CASE SUMMARY REPORT (EPSDT)

Michigan Department of Social Services
Michigan Department of Public Health

1. Printing Date	2. Claim Reference Number

3. Grantee's Name	4. Address	5. City	6. Zip Code	7. Telephone No.

8. Co. Code	9. Case Number	10. AP Load Number	11. Serv. No.	12. Request Date	13. Check Appropriate Box ☐ Non-HMO ☐ HMO

TOTAL FAMILY

14. Pres. Refusal Code	15. Appt. Date	16. (No) Show	17. Appt. Date	18. (No) Show	19. Appt. Date	20. (No) Show	

INDIVIDUAL RECIPIENTS

21. Client's Name	22. Birth Date	23. ID Number	24. Date Last Screened	25. Agency and Clinic Last Screened

26. Pres. Refusal Code	27. Appt. Date	28. (No) Show	29. Appt. Date	30. (No) Show	31. Appt. Date	32. (No) Show	33. Past Refusal Code	34. Past Refusal Date	35. Ref.

36. Client's Name	37. Birth Date	38. ID Number	39. Date Last Screened	40. Agency and Clinic Last Screened

41. Pres. Refusal Code	42. Appt. Date	43. (No) Show	44. Appt. Date	45. (No) Show	46. Appt. Date	47. (No) Show	48. Past Refusal Code	49. Past Refusal Date	50. Ref.

51. Client's Name	52. Birth Date	53. ID Number	54. Date Last Screened	55. Agency and Clinic Last Screened

56. Pres. Refusal Code	57. Appt. Date	58. (No) Show	59. Appt. Date	60. (No) Show	61. Appt. Date	62. (No) Show	63. Past Refusal Code	64. Past Refusal Date	65. Ref.

66. Client's Name	67. Birth Date	68. ID Number	69. Date Last Screened	70. Agency and Clinic Last Screened

71. Pres. Refusal Code	72. Appt. Date	73. (No) Show	74. Appt. Date	75. (No) Show	76. Appt. Date	77. (No) Show	78. Past Refusal Code	79. Past Refusal Date	80. Ref.

81. Client's Name	82. Birth Date	83. ID Number	84. Date Last Screened	85. Agency and Clinic Last Screened

86. Pres. Refusal Code	87. Appt. Date	88. (No) Show	89. Appt. Date	90. (No) Show	91. Appt. Date	92. (No) Show	93. Past Refusal Code	94. Past Refusal Date	95. Ref.

96. Client's Name	97. Birth Date	98. ID Number	99. Date Last Screened	100. Agency and Clinic Last Screened

101. Pres. Refusal Code	102. Appt. Date	103. (No) Show	104. Appt. Date	105. (No) Show	106. Appt. Date	107. (No) Show	108. Past Refusal Code	109. Past Refusal Date	110. Ref.

111. Contact Dates	112 Level of Contact Check (✓)			113. Service Provided - Check (✓)										
				Day Care	Transportation					Follow-Up Transportation				
	Letter	Phone	Person	Arranged	Requested	Bus Ticket	State Car	Own Car	Other	Requested	Bus Ticket	State Car	Own Car	Other

Refusal Codes

01. Own Doctor
02. Child Healthy
03. Recently Screened
04. Not Interested
05. MA Closed-Ineligible
06. In a Health Program
07. Cannot Locate
08. Out of Area
09. Reason Not Known
10. Repeated No Show
11. Other

(No) Show/ Not Screened Codes

01. Screened
02. In School
03. Illness
04. Other Appointment
05. Forgot
06. No Transportation
07. Kept Appt. Not Screened
08. Cancelled
09. Other
10. Reason Not Known

Remarks

114.

☐ 1 of 2 Pages

Workers Signature

Date

DSS-232-A (Rev. 5-79) Previous edition obsolete. Replaces DSS-232 which is obsolete.

EPSDT REPORTS

Name of Report	Purpose	Frequency	Source of Report
1. Eligibility Listing	Unduplicated listing of clients to be contacted regarding EPSDT Beginning point for Case Management.	Monthly	CIS tape & EPSDT History (Outreach Module)
2. CASE Summary Sheet	Printed at time of listing for all new cases. This sheet is used by Outreach Worker as a summary document for case files. PReprinted with Recipient Data rather than transfer info to form.	Monthly	Outreach Module
3. EPSDT Letter	Public Relations document to clients advising them to contact their caseworker to arrange an appointment if they wish to. Produced when listing and summary documents are.	Monthly	Outreach Module
4. Outreach Case Management Report	Reports work loads, work in process and production volume.	Monthly	EPSDT Case Management Module
5. Follow-up Report	Listing of clients screened and referred but not seen by the provider (no invoice received). Forwarded to county follow-up for further investigation.	County's option	Condition of no match bewteen referral and paid claims.
6. Immunizations Needed at Time of Screening	Shows how many and what types of immunizations are needed by EPSDT recipients.	Semi-Ammual	Screening

EPSDT REPORTS

Name of Report	Purpose	Frequency	Source of Report
7. Comparative Summary of Immunizations Needed	Shows agency by agency comparison of immunizations needed.	Semi-Annual	Screening
8. Comparative Summary of Health History Findings	Reports number of children under care, or referred because of a finding(s) in the health history.	Semi-Annual	Screening
9. Comparative Summary of Referral Outcomes	Referral outcomes by planning areas	Semi-Annual	Screening
10. Referral Outcomes by Type of Test	Shows if a referral, based on a condition found in testing, is treated.	Semi-Annual	Screening
11. Referral Outcomes by Physical Inspection Category	Shows if a referral, based on a condition found in a physical inspection is treated.	Semi-Annual	Screening
12. Referral Outcomes by Provider Category	Shows if a referral to a provider group has been treated.	Semi-Annual	Screening
13. Reasons for Refusing Screening	Presents most common reasons for refusing screening.	Monthly	Refused Screening Forms
14. Summary of Screening and Referral by age and race	Fed. reporting	Semi-Annual	Screening
15. Comparative Summary of Screening and Referral	# and % screened, referred or under care	Semi-Annual	Screening
16. Referrals according to Type of Test	Data can be used to determine unusual distributions of suspected abnormalities	Semi-Annual	Screening
17. Referrals based on Physical Inspection	Data can be used to determine unusual distributions of suspected physical problems.	Semi-Annual	Screening

EPSDT REPORTS

Name of Report	Purpose	Frequency	Source of Report
18. Referrals by place of Referral	Gives an indication of the load imposed on various health care providers by the screening program.	Semi-Annual	Screening
19. Reason for Referra by Place of Referral	Demonstrates based on type of referral the referred provider type	Semi-Annual	Screening
20. Referrals by Category of Referral	Reports referrals according to four major categories; Nutrition, Health Education, Chronic and Other.	Semi-Annual	Screening
21. Nutritional Analyses by Age Group	Demonstrates the Hematocrit values per age group	Semi-Annual	Screening
22. Federal Reporting	Federal reporting	Monthly	EPSDT System
23. Eligibility and Penetration Count (by recipient)	Reports penetration of EPSDT screening by county in relation to target population.	Monthly	EPSDT System

HHS DEPARTMENTAL FEDERAL REGULATIONS FOR FEDERAL FINANCIAL PARTICIPATION (FFP)

Ronald Gwyn
Director, Division of Systems Review
Office of Methods and Systems, BPO, HCFA

Joseph S. Strnad
Director, Division of State Systems,
Office of Management and Systems
Office of the Secretary, HHS

MR. GWYN: I am Division Director of the Division of Systems Review and Evaluation. We are primarily the bad guys that come out and do the certification reviews; review the advance planning documents; review implementation plans and contracts; review amended APDs, revised APDs, and further amendments to APDs. But we are exposed very heavily in the technical area.

I heard some comments earlier today with regard to the complexities of computer systems, how they are becoming more and more advanced, more and more complex, which does place a demand on the industry to have more highly sophisticated equipment and technically competent people to utilize these systems. When I was in private industry, we thought we had a system that did everything. We asked somebody to ask it a question, and they asked it a farfetched question, and they said, "Is there a God?" For two and a half hours that computer lit up; direct access drives were being accessed; and, after about three hours, it printed out three little words, "There is now." So maybe we think we have the answer to everything.

On February 6, 1980, there was a Federal Register publication, Volume 45, Number 34, announcing a change to 45 CFR, Part 95. DHEW, at the time, had announced an increase in the threshold figure, for prior approval purposes, from $25,000 to $100,000. Basically the regulation just states that the change raises the HEW prior approval threshold for most State and local government ADP acquisitions. It further states, "We are changing the present prior approval threshold of $25,000 in 95-611(a) to provide that the State shall obtain prior written approval from the Department when it plans to acquire ADP equipment or services that it anticipates will have total acquisition costs of $100,000 or more in Federal and State funds over a 12-month period, or $2000,000 or more in Federal or State funds for the total acquisition, unless the acquisition is noncompetitive from a commercial source.

MR. STRNAD: When Bob Nakamoto called me up, six or eight weeks ago, and invited me to this conference to discuss the change in the regulation which Ron Gwyn has just referred to, I accepted immediately, because I decided I could probably say what the change was about in one sentence, which would be undoubtedly the shortest speech in history, and that would earn me a trip to bourbon country, which I looked forward to very much.

So, yesterday, in the nice, balmy, warm Washington weather, with the cherry blossoms blooming I donned a nice, light summer suit; I boarded the plane and had visions of a nice mint julep on arrival here in Louisville. Of course I learned when I arrived that Spring hadn't come yet to Louisville. A little later on I suddenly learned that Louisville, of all places, shuts down and closes up tight on Sundays. The last time I had run into that was many, many years ago in a little town in Pennsylvania that had "blue laws"; if you even spoke loudly on Sunday, they'd put you in jail; and, if you didn't belong to the local Moose Club, you were just in bad trouble. But, things have perked up today. It has been an interesting conference. I've learned a lot, and it's nice to get here to see a lot of friends, and I hope to make a lot of new ones.

On the assumption that there are a lot of persons in this room who are not familiar with the basic regulation, the procedures under which States obtain Federal financing for ADP systems, I think I would like to give a little background that led up to that regulation, then explain the change. I know there are some here that we've dealt with before and they are very familiar with this; I realize there are probably new people that could use a little bit of that background.

The requirement for recipients of Federal grants to obtain Federal approval of ADP acquisitions has been around a long time. We traced back the history of it to the Bureau of Family Assistance issuance in 1965, which required grantees to obtain approval of the grantor when they wanted to acquire ADP services or equipment. Looking back through the historical records, it's not clear exactly why this particular type of administrative expense was singled out for this special treatment. I think it is probably the only one that requires that special approval. But it appears, in looking over the history of the period, that it was probably due to the high costs of computers at that time, and the very poor results that were occurring in private industry, and in the Federal and State governments. In new computer undertakings, there were many, many failures. And, finally, the Brooks Bill came a little bit later and forced Federal managers to take a hard look at ADP procurement and management. Federal managers concluded that this particular technology, which was costly, which was new, which had such a heavy impact on programs and how they are managed and administered, needed special attention. These same conditions, to some degree, still exist today. We still have many projects, inside and outside of government, that are poorly managed and fail, and are abandoned. While the cost of computers has dropped dramatically in terms of output, automation is still a very costly thing and a very large part of some State budgets. For the Federal government, as a whole, the cost of its participation in State ADP expenditures we estimate at $750 million to a billion dollars. You name it; nobody knows. But it is a very, very large figure that goes into ADP expenditures.

And, of course, there are the budget constraints that are becoming more and more important, and so we see, from the Federal viewpoint, that the need to control and watch ADP expenditures still exists. And we feel that in the 1980s, we're probably going to see even a greater need for everyone observing ADP and ADP acquisitions and expenditures. Because as we go in to the 1980s, I think there is no question that if we thought we had an information explosion in the past, we're going to have a much greater explosion in this decade and in the following decade. We're going to have to use information to manage our other resources. Information is going to be the thing, I think, that makes it possible for this nation to conserve those other resources, to lick inflation, to manage to exist in the decades ahead. We cannot use the capabilities to automate -- the people, the machines, and so forth -- unwisely because the resources we use to automate to do these things will be very, very critical resources that we're going to have to spread very thin to get the job done. We are going to have to use these resources judiciously to do the things that are absolutely essential, and get rid of the things that really can't be justified, because I think the people, and so forth, just won't be there to do the job. And I think this point is brought out by the new Brooks Bill, House Resolution 6410, which has passed the House. The Senate is going to pass a very similar version, and it undoubtedly will be signed into law because it has the support of the Administration. But, basically, what the Brooks Bill does, is set up an Office of Information Management Policy in the Office of Management and Budget, which will be comparable to the Office of Federal Procurement Policy in terms of managing our Federal information management practices.

I think the significance of this bill and what it will do to the Federal agencies and I think, in turn, to the States to deal with, can be brought out in one paragraph from that legislation. It says, "Each agency will" -- and that would be, in this case, you -- "systematically inventory its major information systems and periodically review its information management activities, including planning, budgeting, organizing, directing, printing, promoting, controlling, and other managerial activities involving the collection, use and dissemination of information."

The primary thrust of this bill is to control paperwork, and it's going to lay on the Federal agencies a heavy load of watching what they lay on the public and the States in terms of information collection, information requirements. At the same time, it's going to require the Federal agencies to look at those information resources that are being used in this area. And I think that this trend with greater emphasis on the need for managing information collection, is going to result, in time, in a spinoff in what we can do with relation to the States; in other words, the same emphasis on reducing the amount of burden that we lay on the States will be tied to reducing the amount of unnecessary automation and the amount of unnecessary expenditures out in the States to do these jobs. So, there's going to be a tradeoff there, and I think that you'll find that as the Federal budget gets tighter and tighter, it's going to be harder and harder to justify these new initiatives, even though they are very, very important to program managers at your level and at the Federal level. I think this particular bill and its impact over the next five or ten years is going to be very, very important for all of us to watch in terms of what we are trying to accomplish.

Let's get a little bit into the process, for those of you that aren't familiar with it. States are now required to submit to HEW for prior approval for all their ADP acquisitions the following: equipment and services, a planning document, the RFP, and, in some cases, the contract.

Previously, the threshold was $25,000. Any acquisition of ADP equipment or services of that amount required HEW approval. The change to the regulation has boosted the threshold to $100,000. Now it reads that if you're going to expend $100,000 in a 12-month period, or $200,000 for a total acquisition, it requires prior approval. We made this change at the request of the States and deliberately to reduce the burden on the States, because getting the prior approval was an additional burden. Also, there is a requirement for any service agreements that you have with your State data processing organizations, to obtain prior approval.

Now, the way the system works, you send your requests for prior approval as required by the reg, to the Office of the Assistant Secretary for Management and Budget, and our job is to take them and to farm them out to the components if they are multi-Principal Operating Component (POC) requests. If they are single-POC requests, we send them right to the component involved and they make the final decision.

In the case of MMIS, with which you are all particularly concerned, any requests that come in for an MMIS or a change to an MMIS, or an acquisition of equipment to support an MMIS, we get and pass right on to HCFA; they make the decision and give you the answer through their regions.

In the case of the multi-POC requests, it's a little different proposition, and this is the type of system that involves two or three or four of the components. We farm the requests to them; they make the decision on how their money will be used and whether they can support the system and project. They send the requests back to us and we, in turn, prepare an answer for the signature of the Assistant Secretary for Management and Budget, which goes back to the State. In this process of receipt of your request and farming it out, we distribute copies to everyone who would have some concern and some interest in the transaction: to the regions, to the Division of Cost Allocation, and an acknowledgement back to the State. We try to keep everyone who has a concern with the acquisition and a concern with the function informed as to what is happening.

Now, why do we feel that it is necessary for these documents to be reviewed and approved at central level? Well, the advance planning document is, we feel, the most important, because we feel it is very, very important for the project to get off on the right foot at the start. The advance planning document states the need, the approach, the alternatives considered, the costs, the impact on organization, and so on and so forth. And we found that if enough time is invested in this front end planning process, it will save time and effort and failure later on. The next document, the request for proposal that has to come in, is the thing that lays on the contractor what you expect him to deliver. All too frequently, the RFPs are not clearly written, are not specific enough to get you a good contract. Again, we feel that this review gives you the benefit of some extra knowledge back at Washington, of other experiences, to help you get a good RFP and, consequently, a good contract. I think, all too frequently, we criticize contractors for not producing or not delivering for us, and in many cases the fault lies in the original RFP or in the contract, itself.

Now, to assist the States in preparing these documents and to facilitate them getting through and approved and back to you -- because, really, we want to approve these things, we want you to automate, we want you to get the Federal money to get these jobs done, which are so important to your administration and management -- we published a set of review criteria for your use in preparing these documents and, basically, they tell you what the HEW components look for when they are reviewing the documents.

Last Fall, we put out the review criteria for the advance planning documents for systems, equipment, services and for service agreements. It was handed out at the American Public Welfare Association meeting and it had been mailed out prior to that time.

More recently, we published the review criteria for requests for proposals and systems specs, and that will be the last group we'll put out for this purpose. Again, these documents represent the coordinated input of all our components as to what they think they ought to consist of. As you know, we sent them back to the States for State input, and we were able to change and include advice from the States. And, basically, they represent kind of a consolidation of everybody's thought as to what ought to be in these documents to produce the proper product.

Really, that's the purpose, to produce a proper plan, a proper RFP, and a proper contract. I have a few extra copies I brought along here today in case anyone is interested in any of those criteria.

What can the States do to facilitate the review and approval of their requests, so that they'll get through, they'll get approved, and you can move on with your acquisition? First, consider the criteria. They lay out what the components are looking for, so if you follow those closely, your chance of getting through properly and getting approval is that much more enhanced. Basically, the components' viewpoint is that the acquisition must be necessary and the cost must be reasonable. You want to tell them those things up front, just exactly what you are going to be doing. The criteria lay out all the things they are looking for.

Two other things are important. These submissions have to be signed by the proper person. Too frequently someone signs the request who is not authorized. It has to be the head of the agency or someone he/she designates can sign for him/her, because when requesting Federal funding, the request has to come from someone in a proper position. There have to be sufficient number of copies so we can farm the thing out, as I indicated. And if you don't provide them to us, we can sometimes xerox them if they aren't too large. But if they are large documents we need enough copies from you to get out to the various people who have to act on them.

Lastly, make sure you address the requests correctly. The address is stated in the regulations. Mail it to the right place and you'll save time, because we try to move it out to the components within two days after we get it. If it sits around in the wrong office for a week, you've lost time.

Again, one important point I'd like to make, based upon a couple of year's dealings with our components. I think they all want to support you in your automation efforts. They realize that automation is the way you can get a very big job done efficiently. It can improve your management and put you in a better posture to support their requirements, and they want to do all they can to help.

The regulation is now in effect that boosts the threshold to $100,000; it was effective on February 19th with its publication. It had one other requirement in it that I'd like to mention. It requires, for acquisitions from $25,000 to $100,000, that you send us a notice of this acquisition, a simple notice. We lay out a few things to provide us. The purpose of that is to keep you from going through with an acquisition which might be a mistake at that point in time. There are a lot of things happening at the Federal level and you've heard some of them from the stage here today. You could be proceeding down a path on an acquisition that you really shouldn't be pursuing because of something that is in the mill that is going to break very shortly. So these notices give HCFA a chance to see what you are doing and if it's right in line with what ought to be done, there is nothing more to it. If you happen to be starting something, though, that is a mistake at that time, they get on the phone and let you know.

To summarize, we see that in the 1980s, there's going to be even a greater expansion of information as a resource to better manage the nation's resources. That information collection and information use, itself, will require better management. And, last, our resources are becoming increasingly scarce -- ADP resources are one of them -- and we'll have to, I think, conserve them and use them wisely. And we're back there to try to assist you in that, and you all know our phone numbers. Please do not hesitate to call on us if we can be of help.

We've had many visits from States which have been very profitable from our viewpoint and for the States, and we're there to help you. I'm sure that I speak for the components also.

Now, there is one issue with respect to the new change, which I am sure Ron wants to bring up, and we'd like to discuss that first and then maybe we can take the questions.

MR. GWYN: It was believed that there was some possible conflict between the 45-95 introduction that Joe has been referring to here, and to a regulation that we operate under for higher level matching, and that's 42 CFR 433, subpart (c). This is in regard to the 90-75 percent matching funds for MMIS DDI and operation.

Chuck Booth tried to clarify this issue by writing a memo to the General Counsel. The issue that Chuck raised with OGC is the current HCFA understanding that 45 CFR 95, subpart (f), applies to ADP expenditures matchable at 50 percent, under Section 1903(a)(7). But the provisions of Section 1903(a)(3) and 42 CFR 433, subpart (c), are explicit statutory provisions, exclusively applicable to expenditures for ADP equipment and services, which are matchable at a rate of 75 percent or 90 percent. Is this application of authorities to funding correct?

Also, we understand that the 12-month period under 45 CFR 95, subpart (f), need not equate to a fiscal or calendar year. It is my understanding that we did hear from the Office of the General Counsel, and we have taken a position over the years that regardless of amounts, all items, all requests, which are for a higher level funding at the 90 or 75 rate, are subject to prior approval. And General Counsel's comment was, yes, it is, which, in essence, we are saying that regardless of the $25,000 or the $100,000 or what have you, when the request applies to higher level matching, we, HCFA, are requiring prior approval.

The second part of this, for the 12-month period -- any 12-month period, it doesn't follow a calendar year or fiscal year; just a given 12-month period. So this was the difference between the 42-433 issue and the 45-95 issue, which we just got under the wire and got clarification from General Counsel, I guess that was late Friday afternoon, that we wanted to bring it to your attention.

So, at this time, if you have any questions, maybe between Wes and Joe and myself, we can try to address them.

MEDICAID PERFORMANCE STANDARDS

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MR. JANSAK: I will talk a little bit about the basic issue of why standards, particularly for MMIS. One, Congress, of course, provides, through the statute, for the extra 25 percent FFP, and Congress expects value for its bucks.

Second, GAO, a Congressional arm, went into several States, found some problems with edits, data exchange, and other information. GAO said there was need for HCFA, not only to certify an operating system, but to go back to obtain ongoing assurance that the system is producing at a demonstrated level of performance.

The States, of course, have been aware of the need for performance standards, and the TAG groups have been working for at least a year or so, if not longer, drafting proposals. Since the reorganization last June, Newt Dikoff and his people have been working with the TAG and with the systems people to come up with a proposal for MMIS review standards. We have had lots of State help, which we appreciate. We have had lots of regional office help, which we also appreciate. We view this as an evolutionary process, and we will tinker with it and improve it as time progresses.

It is important that standards be up front, and that they be objective. We also want them to be output oriented, as much as possible, and not process oriented. This gets us into a slight problem because the fastest way to process claims, of course, is to turn off the edits. So, we do have to look at the process, and we envision the regional office, in their State assessment process, to go in to assure that the specifications for the system and the rules and regulations are being applied and that the process is, in fact, being carried out.

Then, we will look at the output measures, that is, the speed of claims processing of the system. Hopefully, the quality control devices that will be used in terms of accuracy, and also any other statistical or objective advice that we can find. Hopefully, some day there will also be cost information related to common definitions of claims and common financial definitions.

A draft package has been released to the State advisory groups. It is also being field tested in Idaho, and was tested in the State of Michigan. It is going to be tested in one or two other States, and it is going to be revised, based on input from work groups in the regions and States. And we hope, in October 1980, to have a reasonably good package to turn over to the regions for implementation in Fiscal Year 1981.

This will be, in fact, a full scale test of the system without formal sanctions. This period of time will allow us to tinker. We will take your comments and criticisms, and try to improve the system.

I would like to say, in closing, that standards are pretty important in life, and not only in the health care scene. I was reading this morning that Ford Motor Company wiped our 15,000 jobs, and 4,000 of them were in a plant in Mahwah, New Jersey, near New York. The plant, which assembles compact Fairmonts and Zephyrs, was closed because the quality of cars has been the worst of any Ford plant in North America. I think that gives us a message that the private sector and Congress are looking for quality control.

You are going to be looking to your fiscal agents for quality control. And we will be looking for quality control. The taxpayers will be examining all of us. The closing of this plant is one manifestation of where quality control had a very strong impact upon an organization.

And I think, in times of economic recession such as now, there will be lots of emphasis on meeting objective standards of performance.

MR. MILLER: Before we get into the discussion of the standards themselves, I though a few words about STAG, the makeup of it, and some of its purposes, would be appropriate. STAG (formerly N-TAG) was founded in January 1979, and its first meeting was held in February 1979. Its purpose was initially to assist in the development of performance standards and to review and comment on some of the proposed regulations. In addition, we would act as a sounding board for HCFA central office and would assist in the dissemination of technical information. It was a rather loosely formed organization, but in the late Fall of last year, we developed some membership criteria to provide for an orderly progression of members.

STAG is made up of seven State members plus a representative each from the APWA information systems management group and the State Medicaid Directors' Council. In 1979, the members were from the States shown on the left. (Exhibit I) In late fall, we developed a membership policy that each State representative would have a two year term and that roughly one-half of the membership would rotate at the end of each year. The States which dropped off in 1979 were New Jersey, Texas, and Michigan, and they were replaced by Montana, Nebraska, and New York.

New members were solicited by a letter sent to the head of the single State agencies for all of those States which were not currently represented on the committee. Nominations were screened by STAG with the committee itself making the final selection of the members. What we tried to do during that selection was to obtain as broad a geographic representation as possible. We wanted to have a good mix of large States, small States, and medium size States. We also wanted to have States which represented the various means of processing, such as inhouse or fiscal agent.

Bill Corboy will discuss what the TAG group took as its first task, which was to assist and make recommendations on the development of performance standards for MMIS systems.

MR. CORBOY: I am Bill Corboy from Medicaid, New Jersey. And last year, as a result of Len Schaeffer's directive that performance standards be developed, the NTAG group was put together, and I was coerced into joining that by my director.

Primarily because we were in the stages of planning our certification, and to protect our own interests, we wanted to ensure that that certification would stick for at least a small period of time before we were reassessed.

So, in accordance with that, NTAG began its work toward developing what we hope are good functional standards and good performance standards for a Medicaid management information system.

What I am trying to deal with here is the criteria we used to establish the standards, and they were primarily the following: that the standards would be categorized into functional performance standards; and, the state of the art is such that only a limited number of performance measures that could be readily applied, were identified and recommended. Two, the standards should address what are considered critical functions of an efficient Medicaid program. No attempt was made to set standards for every functional requirement of an efficient MMIS. These standards would be limited to those which can be readily evaluated or measured. As State and HCFA technology advances, as well as the level of MMIS usage, and sophistication modifications and additions to these standards would be made.

Some standards go beyond the scope of an automated information system, and in the MARS and SURS subsystem areas, the standards, in particular, an efficient functioning of the system only can be measured by actions taken in response to information generated by the system.

Standards should be developed attempting to recognize the uniqueness of each State's Medicaid program, specifically with respect to claims volume, recipient and provider populations, and the benefit package in that State.

Performance standards cannot be measured against the national norm, which was very important, which has the built in assumption that some States will not qualify. When you establish norms, you have both ends of the curve, and, naturally, you will have those that would not qualify, and we did not want to get into the position of establishing performance standards which would lend themselves to any State not being able to qualify.

The NTAG group performs a function that I think is necessary as long as you have a marriage of State and Federal agencies attempting to run a program. And what NTAG or any TAG group serves is to ensure that the interest of both are served and that one doesn't become overbearing on the other.

During our review of many of the suggested performance standards, a HCFA paper was prepared which I am using to show that NTAG itself did protect the interests of the States. In particular, the point I want to make is that there was a point in time when an attempt was made to establish some norms or some method of measurement that we didn't feel was particularly conducive to the States.

So, I am going to read from a letter that was drafted and sent to the director with respect to this point of view. The paragraph goes, as follows: "Although the National Technical Advisory Group wholeheartedly supports the establishment of Medicaid performance standards, we substantially disagree with the process used to develop that report and with many of the recommendations within. In spite of the fact that the introduction acknowledges our input and efforts, the draft report contained the specific concepts and items to which we most strenuously objected.

"Although there was a clear consensus of opinion during our Detroit meeting in May against the use of only four output performance indicators for the recertification of a Medicaid system, and especially the use of national norms as a measuring device, both concepts remained in the report unrevised.

"We feel that the four output performance indicators do not measure a system in sufficient detail to provide a base for accurate funding determinations, and that the use of the national norm is discriminatory in its inherent failure by at least a segment of the State population."

And I thnk also, at that particular point in time, we were confronted with a suggestion that the genreal systems design be abandoned and that an integrated data base be developed. And that stuck particularly in my craw because, although the general systems design leaves a lot to be desired, the proposition of an integrated data base in lieu of it, with little substantiation for the rationale, to me, I thought it was premature.

So, in this particular letter to the Administrator, we said, "As a group, we do not support the abandonment of the current general systems design and its arbitrary replacement with an integrated systems design. This concept was never discussed with NTAG, and we do not believe that it has merit in relation to the cost of such an undertaking. We do, however, support the revision of the present general systems design to reflect new technologies and methodologies."

This is not to demonstrate that we were constantly at one another, that it was a Federal-State adversary relationship, and that NTAG feels, as do I, that we should protect the interests of the States, especially any TAG, if you are included. I think that is a very important role that we must play in advising the Federal government of our problems in implementing what they deem to be necessary for a management information system, and in this case, Medicaid's management information system.

MR. MILLER: The standards which we developed, I want to stress, were recommendations to HCFA and that we presented essentially two sets of standards. We determined that there are some things in a system that can be measured, and these we called performance standards. Second, we determined there are some things in a system that cannot really be measured, but they must be there in order to have a good reliable system. We called these functional standards so that we weren't continually getting our terminology mixed up. Thus, we developed two sets of standards that we recommended to HCFA: performance standards and functional standards.

Our next problem was how to measure a system for certification. We had two areas of concern which were the initial certification process and the periodic assessment or reassessment. We wanted to be sure that we covered both of these areas of concern, and we felt that we did not necessarily want to cover both areas the same way. Therefore, we needed to develop a measurement criteria. We also wanted to have some flexibility because we realized that right now we have certification and assessment at a full 75 percent level. However, we felt that we needed to take a look at some other alternatives and to be creative and innovative to develop measurement criteria which would, in fact, support several different approaches. (Exhibit I)

The first approach is the current system, certifying the entire MMIS at 75 percent. But there are other alternatives. Subsystems could be certified, or provider types certified, or even geographical areas could be certified. We wanted to have a measurement system that would allow us the flexibility to do this. Another approach that we wanted to include was the incremental funding of systems between 50 and 75 percent depending on how well a system attained the various standards. If, for example, in one area you were not doing so well, you would not lose complete 75 percent funding but would only lose some part of that, depending on how well you were attaining other performance standards or objectives.

Finally, by putting both of these thoughts together we have incremental funding for pieces of systems, subsystems, provider types or geographical areas. We recognize that legislation does not permit this right now, but we felt that a good innovative look, a creative look, at how systems are certified needed to be done, and we wanted our measurement criteria to be able to support these approaches.

In order to do this, we developed a generalized approach (Exhibit IV) to decide in an objective way, whether an MMIS should be certified. Our approach was simply to choose some building blocks which I will describe in a minute. These are some of the major areas that we felt were important to certification. Our second task, then, was to develop a measuring system for each of the building blocks. Third, was to combine the building blocks for the specific certification or assessment situation which was applicable. In other words, for certification, you might use four or five building blocks, whereas, for assessment, to continue the funding once you are initially certified, we may only utilize two of those building blocks. Finally, we recommend how to calculate an overall score and a minimum achievement for each building block in order to be certified.

What we hoped this would provide was a comprehensive package which we could recommend to HCFA which would be flexible, and would be easy to modify, so that when new regulations were developed, we could easily integrate new standards into that package without a major overhaul or a major revision. In addition, we could adjust the levels of the standards very easily as we gained experience with the system. We are very concerned that we do not have enough data, and we don't think that HCFA has enough data right now to be able to set realistic standards for the way that a system should perform. Therefore, we wanted to develop a general system so that these standards could be easily modified.

The building blocks that we finally agreed upon that HCFA can interchange at will in order to develop various certification criteria are data elements, a Federal report set, performance standards, and functional standards. (Exhibit V)

We feel that there is a minimum set of data elements that a system must support. We do not feel that the data elements in the General Systems Design, GSD, are necessarily that set of data elements. This needs to be reviewed. However, we clearly need a set of data elements that a system must support, and the system must support these without exception.

Secondly, we feel that a Federal report set of data elements must be developed that can be required from all States without exception. It should be clear; it should be concise; and, there should be no questions about it.

The third building block, of course, is the performance standards themselves, and the fourth building block is the functional standards that we developed. If you will recall, we split the standards into two areas, one that could be measured as to degreee, and the functional standards, which are simply there or not there. The actual measurement that we recommended was to give an equal weight to all of the standards. We feel that getting into a weighting process with standards is a counterproductive exercise. Therefore, we recommend a constant score for each standard of, say, 100 points or 1,000 points, to give us some flexibility to work with the overall score.

We were also very concerned that the measurement of a criteria be some reflection on how well that criteria is attained. What I mean by that is, if someone fails a criteria by a small amount, they should not lose all of the points associated with that criteria. We are not too concerned about where we set the level right now as we need experience to determine that. In other words, the measurement criteria for each of the standards should reflect the degree of attainment of that standard, and I think that we have developed a way in which that can be done.

As an example, one of the standards is that 95 percent of the provider certifications must have been issued consistent with the State plan. (Exhibit IV) In other words, whatever the State plan says about issuing a provider certification is what we want to use as a standard. We acknowledge that there are going to be some errors, so 100 percent of them do not have to be issued that way. We chose 95 percent. We do not, at this point, feel that it is productive to get into arguments about whether 95 percent is the right number, or 97.5 percent, or 80 percent, or 99 percent. We frankly don't know what the right number is. We chose a percentage that we felt comfortable with and that we felt was realistic. What we are interested in is how do we measure a standard and how do we put these measurements together in a fair and equitable manner. To measure this particular standard we felt that there were three things that needed to be done. First, the team performing the measurement would check State policy. Second, they would draw a sample, and third, they would check that sample against the State policy. Points would be awarded according to a formula for each of the standards. In this case it is 100 times the ratio of the number that were consistent with the plan, over the number in the sample, divided by .95.

What this measurement criteria does, if you look at it, is award all 100 points if you meet the standard, which in this case is 95 percent. However, if you miss the standard by some amount, you not receive zero points for the criteria; you get somewhat less than 100 points depending on the degree by which you miss it. The further you miss the standard, the more points you have taken off. We feel that this is a very important part of any measurement criteria that are developed. Similarly, if you look at that formula, it does something else for you. If you, in fact, exceed the standard, then you will get more than 100 points, depending upon the degree by which you exceed that standard. This is something that we wanted to leave in. We initially felt that the maximum would be 100 points for each standard but we felt that this technique would give us more flexibility in incremental funding to exceed the 75 percent level if we ever got legislation which would allow that.

This is the measurement criteria for each standard. Now, let's see how we could put some of these together in order to determine certification or a continuation of funding under an assessment. Here again, this is a recommendation of various ways that it can be accomplished. We think that a great deal of detail work must be done by HCFA if they, in fact, accept this methodology.

Let's take, as an example, that we want to allow incremental funding, between 50 percent to 75 percent, on a total system. (Exhibit V) Let's assume that we have chosen to utilize all of the building blocks which we earlier defined. In other words, certification will be granted if the following criteria are met: all data elements are present; all of the Federal reports can be produced without exception; a minimum score of some number of points to be determined is achieved in the performance standards; and, finally, a minimum total score of a certain percentage of functional standards is met.

If all of these criteria are met, you are certified; if all of those criteria are not met, you are not certified or you do not have the continued matching. In this case, because we wanted to do incremental funding, we came up with the calculation of what the match would be: the weighted percent of 50 percent by which the performance standards were achieved, added to the base of 50 percent.

Basically, we feel that this recommendation gives us a comprehensive package for certification and assessment, and it gives us more than that. It gives us a flexible package that measures how well we are achieving the standards, not just are we or aren't we achieving those standards. This was the basis of our recommendation to HCFA, and John is now going to discuss this recommendation and some of the things that HCFA themselves have been working on since this was submitted.

EXHIBIT I

CERTIFICATION/ASSESSMENT APPROACHES

- SINGLE ENTITY AT 75%

- SUBSYSTEM, PROVIDER TYPE OR GEOGRAPHIC AREA AT 75%

- SINGLE ENTITY WITH FUNDING FROM 50% TO 75%

- SUBSYSTEM, PROVIDER TYPE OR GEOGRAPHIC AREA WITH FUNDING FROM 50% TO 75%

EXHIBIT II

GENERALIZED APPROACH

- BUILDING BLOCKS
- MEASURING SYSTEM
- COMBINE BUILDING BLOCKS
- MINIMUM OVERALL ACHIEVEMENT AND MINIMUM ACHIEVEMENT OF EACH BUILDING BLOCK

EXHIBIT III

BUILDING BLOCKS

- DATA ELEMENTS
- FEDERAL REPORT SET
- PERFORMANCE STANDARDS
- FUNCTIONAL STANDARDS

EXHIBIT IV

PERFORMANCE STANDARD MEASUREMENT

EXAMPLE

STD: NINETY-FIVE PERCENT OF PROVIDER CERTIFICATIONS MUST HAVE BEEN ISSUED CONSISTENT WITH THE STATE PLAN

MEASUREMENT:

1. CHECK STATE POLICY
2. DRAW SAMPLE OF PROVIDERS
3. REVIEW SAMPLE FOR COMPLIANCE

POINT AWARD:

$$\text{POINTS} = \frac{100 \text{ X } \dfrac{\text{NR CONSISTENT WITH PLAN}}{\text{NR IN SAMPLE}}}{.95}$$

EXHIBIT V

FUNDING ASSESSMENT
INCREMENTAL FOR TOTAL SYSTEM
EXAMPLE

BUILDING BLOCKS: DATA ELEMENTS

FEDERAL REPORT SET

PERFORMANCE STANDARDS

FUNCTIONAL STANDARDS

CRITERIA: APPROVAL GRANTED IF

- ALL DATA ELEMENTS PRESENT
- ALL FEDERAL REPORT PRODUCED
- MINIMUM TOTAL SCORE OF _______ POINTS ON PERFORMANCE STDS
- MINIMUM TOTAL SCORE OF _______ % ON FUNCTIONAL STDS

MATCH CALCULATION:

WEIGHTED PERCENT OF 50% BY WHICH PERFORMANCE AND FUNCTIONAL STDS ARE MET ADDED TO THE BASE OF 50%.

MR. JANSAK: Allen has talked about some of the complexities of developing standards, and I will touch on some of these problems along the way, plus give a little overview of where we are going in the development standards for MMIS.

We are going to be looking at the areas of eligibility, claims control, timeliness of processing, duplicate checks, coverage, edits, SURS, MQC findings, and reporting of data, including timeliness and accuracy to HCFA.

An example of reporting, is the MMDS information. Workload information, of course, is elementary. You need that data to have any standard of performance efficiency. You need to have a common definition of claims, as is contained in the MMDS, to describe that information, so there can be some comparison of how fast claims are adjudicated, and by type of claim.

The inpatient bill, obviously, is rather different than a SNF bill, which is more a listing of patient days, as opposed to a line item for drugs and physician bills.

There also has to be an evaluation of whether the State policies are in conformance with the State plan, and whether the State plan is also in conformance with the law. That requires a State assessement over and above the individual claims adjudication.

Another problem I don't think we have dealt with yet, but is a consideration for the future, is the reject rates, the number of cases that are rejected by error in the claims processing system. In terms of claims control, we are also looking at the timely claims processing regs, which are an inherent part of the package. This, of course, is based on Section 2 of P.L. 95-142. The regulations now allow three different definitions of claims, so the regions have to check against each individual definition. I would think it would be logical for us to provide consistent definitions. Duplicate checks, is another problem and, one of the things that GAO pounded upon. Obviously, this type edit is one of the most elementary that should be in any system. That, together with eligibility checks, plus coverage checks on limitations within each State are elementary.

Those areas, to me, are key. I disagree somewhat with what Allen was saying, that is to give every element equal points. Areas like duplicate checks and coverage screens, are very important and have to be very heavily weighted.

In fact, I think there is a lot more money to be saved in these areas than in fraud and abuse reviews. Therefore, there can't be slippage in those areas. But, that again, is a matter of philosphy and discussion. A lot of work is required, and we have had significant input from the States. Also, substantial training will be required by us to assure that the regions are operating in essentially a synchronized manner. We think the annual State assessment will allow the region to indicate to the State, there has been no change in your process, it continues satisfactory, or there has been improvement, or possibly that there has been a problem in some area that they have identified or probably the State identified first. The State assessments use a lot of sampling based on Department of Defense models. We try to find realistic samples because we have limited staffing to do the work. We try to use one sample for a number of activities. But the sampling methodology is a burden to the State because you have to obtain the sample desired. You have to work together with the region so you can somehow come out with that claim sample they want. It is also difficult sometimes to get samples for past time periods. Scoring will be controversial. Whether elements should be averaged together is one issue that Allen alluded to. The analogy, of course, is if you get a 58 in Spanish and passing is 60, should that be averaged in with your 75 or 80 in History. I think probably we can have some averaging, but I don't know how far we can go.

We don't believe in using a curve. All activities should have an opportunity to pass. Although you might have to use percentiles to have your initial cutoffs, before the fact announcement should give opportunity for those, who might well be below that cutoff, to improve and do better in the next round. We have had that experience on the Medicare side, where the Part A standards are now in place. Those standards were set at the 85th percentile, but on a flat line basis, and most of the contractors below that line are making efforts to get over it. I think I will stop at this point to give Howard Stansberry a little time to talk about the Michigan experience, and then we will be back for some questions.

MR. STANSBERRY: Everywhere I go, people are asking me how the test in Michigan came off. I am here to tell you that I feel like it came off real well. I think Paul Allen and Bruce Koslowski approached the test with a very objective attitude, welcoming the approach to review of their system and what the NTAG group had recommended.

We did approximately a month ago, March the 17th, go in. There were five of us, myself as the representative from NTAG, and John Walker from HCFA, and three representatives from the regional office in Chicago. We did do the review. The Michigan staff did, of course, have to help us considerably. We were there for two and one half days. So, we did a very small sampling, pulled 25 claims. We did run them through all the system checks, more or less by the standards provided by HCFA. They have their version of what we have proposed. I think we have distributed those to most everyone on every side. Trying to compare those, there are a few differences in our recommendations and what HCFA has utilized, and the scoring, which you just heard discussed, was one of those.

We did take all 25 claims through the performance standards, checking the edits in the functional standards, the percentiles, according to the HCFA recommendations. We did not use the ratios that you saw utilized here. HCFA has their own scoring methodology. The staff did take us through all areas. We did review all provider types. We say random sampling, but we did sort of select in order that we could review all types of providers in the claims processing area. We did take them to the provider profiling, provider and recipient eligibility, third party liability. We did not do an indepth review of SUR or MARS. I think, at that point, Terri Kowalski, whom you heard talk earlier, was in charge of that group. And I think, by listening to her, you know that Michigan was well endowed with the MARS and SUR concept. We felt like the review went real well. I do feel that Michigan learned from it. They did take some constructive criticisms in some areas. I think they will make some changes.

I think we would all appreciate a review, and if you approach it with a constructive attitude, as Michigan did, we can improve. Anyone who thinks they have got an ideal system and cannot improve is way out.

I have had other people ask, do the Feds really listen to you in you NTAG discussions, do they adopt some of your recommendations? I think the NTAG group has made some recommendations that you will not see on paper or in your guidelines, but I think there are some concepts that are being adopted. We have had some discussion about the curve. NTAG has been very outspoken. We don't want to be graded on a curve. You do see, still, some thinking along the curve line even though John indicated they don't like it. You still see some Medicare concepts towards utilizing that curve in grading. Another area is that utilizing the State input so that you will continue with the NTAG. We do want NTAG and other TAG groups to continue to utilize their efforts in training the Federal people in performing these reviews, one of the things that I will comment on in the Michigan review. Our NTAG representatives had strongly recommended, from the onset, that we felt that in order to have commonality in the reviews, that there should be a team from the central office. Not criticizing the Chicago office or the regional office, we still feel that in order to have an overall common review, it should be conducted by a team from the central office. So, those are some of the areas that we have approached in the NTAG, some of the communications that we have made.

Before I step down, I think we should introduce some of the other NTAG members that have been responsible for last year's work: Bob Melvin from Georgia; Derek Wang from Idaho; Pete Peterson from Minnesota; and, Izanne Leonard-Haak from Pennsylvania. In addition, we have three other members, as it was discussed. Maureen Murray from Nebraska; George Elmendorf from New York; and, Neil Ostby from Montana. These are our new members. So, you will be hearing about and communicating with them for the next year.

MR. JANSAK: I guess, before I go into the questions, there are two things we learned in the Michigan environment. One is that in some of the systems, control is lost for individual claims. That is, you have aggregate information on claims, but individual claims are sort of lost. And this gives you a problem when you are sampling, to see how that system relates to. So, there is an adjustment we have to make for a specific kind of a system. Also, we have to take into account more specifically, in our standards, something that is rather obvious, but sometimes when you get into a certain kind of environment you have to account for it. That is the high volume of so called drug line items as opposed to other claims. Your sample shouldn't be loaded with drug claims even if that reflects that ratio of that operation. I don't think that's consistent. But that is something you have to adjust in stratifying your samples.

THE INDIANA EXPERIENCE

Jon Herbold
Medicaid Division
Indiana Department of Public Welfare

MR. HERBOLD: I am not sure if it was done on purpose, but I feel like I was sucker punched by following the performance standard discussion, because one of the reports I want to discuss is the report that we designed in response to Action Transmittal 79-50, which is the "clean claim throughput report."

What we do in Indiana now is whenever HEW requires a report, we tack everything on we can, what we feel we need, both in terms of additional information and in terms of protecting ourselves. And I think this report will reflect that. What the report is, is a six axis report. We look at the type of bill, as well as the type of provider, "bill" being defined as the type of document in this case. We also look at bills as opposed to claims. We look at clean as opposed to all. We look at seven different static points in the claims processing process. We also look at the number of days and the percentage, as well as the raw number. The beginning of the report, which consumes about seven pages, is designed to be a summary. In other words, it covers the whole span, how long did it take from the time the provider finished providing the services, until the time the check was produced by the system. This example shows, inpatient hospital, type of bill, drug type of bill, medical, outpatient hospital, and Medicare crossover claims. The report also goes into more detail, which gets into the provider type, and here I only care about the processing of all claims. I really don't care about clean claims versus dirty claims. You can see the seven different points. What we have done is go from last service date for home health agencies to check date. We also go from last service date to date of receipt; last service date to billing date; billing date to date of receipt; date of receipt to adjudication date; and, date of receipt to the check date. With this report I can say, as I have done on several occasions, that if the provider sits on the bill for six months, I cannot be responsible for the delay.

We had an interesting experience about two or three months ago where a provider came in, and he was up in arms because of all his claims. Either the claims were rejected or it took a great deal of time for us to process the claims. Well, we went into the current throughput reports, and found out that, in fact, most of the claims that were rejected as a result of clerical errors on his part. They did not give us a correct Medicaid number. They did not give us a correct name, or the name was for the mother when, in fact, the service was provided for the child. In terms of processing the claims, we found out those claims that were "clean" were processed within 15 days. He left, and that was the end of that. Another provider was also on his way in, but we never heard from him.

So, that is the bottom line for this report. I did not bring my copies with me because my intent isn't to say that Indiana is better than anybody else, but just to give you an idea of what we are doing.

There is another report that we have also designed, which we call the "category of service by location report." This report was initially designed by Mr. Stanton to address the problems of ancillaries in nursing homes. Nursing home costs in Indiana constitute, typically, in excess of 50 percent of our total budget. So, it is a very carefully watched area. Ancillaries, specifically the therapies, will constitute in excess of $1 million. While that, in relation to the total budget, is not a tremendous amount of money, to me $1 million is still $1 million.

This report has gone through an evolution. It started out as a basic, one page summary report that Mr. Stanton personally designed. The report generally lays out the type of service or the ancillaries. The report goes down the side with various types of service. They generally conform to the GSD specifications for other reports. However, we have taken that a little bit further. And across the top we have locations of service, for example, nursing home, inpatient hospital, outpatient, and then the noninstitutional services. The report was very useful. However, it was not responding to some very, very specific information requests that we have been receiving from the legislature. As the result of this, we were directed, in Program Review, to reevaluate the report and revise it so it could be more responsive to these types of inquiries. The problem is, as is true of all of Medicaid, it's like trying to paint a moving train. No matter what you do, by the time you are done, you look at what you did and it's not as good as you thought it was going to be when you started. So, we went into the second report, which was a little more descriptive. It still carried about the same types of information. It has the categories of service, and within that, there was an expansion of the locations. Across the top, basically all we did was add the fiscal year to date. Anybody that has worked with MARS knows that units of service mean absolutely nothing. If anything, it just confuses people. They think it means something, and when they find out that it doesn't mean anything and they can't make any decisions based on it, it just causes a whole circle of problems. So, what we finally did is delete the whole thing again, and we ended up with the report that we are now in the process of implementing. The report, right now, is a two part report. The first part is intended to be a summary only, and it is three pages long, and it will literally sit on the administrator's desk. What we have done is delete the whole concept of units of service, and we went to what we call in Indiana "line items." Everybody else calls it a "claim." We looked at an unduplicated number of recipients, and how many recipients have received this service. That is nowhere in MARS. We got the total adjusted expenditure, which is a reaction to our previous report, which did not show adjusted amounts. We got the average dollars per claim on a monthly, as well as a fiscal year to date basis. What we also added on the fiscal year to date was a change over the previous fiscal year, so that it would be fairly easy for a person to look at the report, not only to find out where he is this month, but where he is in the current fiscal year to date, as well as where he is in relation to the prior year. This could be very useful, we hope, in terms of forewarning us when problems are going to be happening. When we institute a policy and the effect should be a decrease in payments or a decrease in amount or a decrease in participation, we look for it. Conversely, if it is supposed to increase, we know that that is going to happen also. At the bottom of the report is a very important area to us and probably with many other States, and that is payments for institutional services -- nursing homes and hospitals. What we have done here is, instead of looking at the claim count, we are looking at the days of care so we can find out what is happening with these recipients. Is the quality of care increasing? If we institute policies, it should increase the quality of care, and also decrease the stay in the hospitals. We will be able to follow this. I think the bottom line for this report is a pointer, telling us where we are going in the future. The report, as you have seen, is very brief in Part 1, and it does not deal with the various categories of service. We also have

Part 2, and it is indexed by Part 1. Over on the left side of the report, it will have a corresponding page, which will index a person back to the details. In the details, for example, it will say audiological services, and it will show each and every location in which those services were provided. And it will provide the same type of information that is arrayed across the top, exactly the same. What we have also tried to do with the report is to keep it static enough to respond to what we know are current issues, but dynamic enough to respond to a program that changes as much as Medicaid. So, what we have done in the programming is tried to modularize the programming itself -- we can slip in new provider types, or we can slip in new locations.

This has been a very exciting report, and it has given us a totally new perspective on what is happening. I am not one to demean MMIS, even though I have a lot of problems. But, obviously, the reason for the report is the fact that MMIS, as it is "speced" out, does not provide this type of information.

For example, if a legislator asks how much we spent on drugs, there is nowhere in MARS that you can get that information. MARS does tell you how much you spent to pharmacies for drugs, but it doesn't allude to drugs that were provided in the hospital setting. So, what we are trying to do, based on our own unique problems, is to fill a gap that is in MARS. Now, in all fairness, I have to say that HEW has been very, very cooperative, and we have approached this as a cooperative venture. And at least in the past year and a half, since I have been in Indiana, I have had an excellent relationship with HEW on most issues.

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WM49-01R                        CATEGORY OF SERVICE AND LOCATION REPORT                                        DATE ENDING:  XX/XX/XX
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WM49-01R
                                        CATEGORY OF SERVICE AND LOCATION REPORT
                                                        PART I                                              DATE ENDING:  XX/XX/XX
                                                                                                            RUN DATE:     XX/XX/XX
                                    EXECUTIVE SUMMARY:  PAYMENTS FOR SPECIAL SERVICES/PROGRAMS              PAGE:         2

                               - - - - - - - CURRENT MONTH - - - - - - - * - - - - - - - - - - - - - - - FISCAL YEAR TO DATE - - - - - - - - - - - - - - - - -
                                                                         *
LOCATION                       UNDUP.                          AVG. $    *  UNDUP.                                  % ALL    AVG.  $
ANALYSIS                       # OF     # OF      TOTAL  ADJ.    PER     *  # OF      # OF     TOTAL  ADJ.    SVCS. OR    PER       AVG $         CHANGE OVER
ON PAGE                        RECIPS LN  ITEMS  EXPENDITURE  LN  ITEM   *  RECIPS LN  ITEMS  EXPENDITURE   SUPPLIES  LN  ITEM PER RECIP         PREV.  FY
                                                                         *                                                                     LN ITEM   RECIP.
       EYEGLASS MATERIALS                                                *
NA       OPTOMETRIST           XXX,XXX X,XXX,XXX  $XX,XXX,XXX  $XXX.XX   *  XXX,XXX X,XXX,XXX  $XXX,XXX,XXX XXX.XX%    $XXX.XX  $X,XXX.XX    XXXX.XX% XXXX.XX%
NA       OPHTHALMOLOGIST       XXX,XXX X,XXX,XXX  $XX,XXX,XXX  $XXX.XX   *  XXX,XXX X,XXX,XXX  $XXX,XXX,XXX XXX.XX%    $XXX.XX  $X,XXX.XX    XXXX.XX% XXXX.XX%
NA       OPTICIAN              XXX,XXX X,XXX,XXX  $XX,XXX,XXX  $XXX.XX   *  XXX,XXX X,XXX,XXX  $XXX,XXX,XXX XXX.XX%    $XXX.XX  $X,XXX.XX    XXXX.XX% XXXX.XX%
                                                                         *
       PHYSICIAN                                                         *
13       ANESTHESIA            XXX,XXX X,XXX,XXX  $XX,XXX,XXX  $XXX.XX   *  XXX,XXX X,XXX,XXX  $XXX,XXX,XXX XXX.XX%    $XXX.XX  $X,XXX.XX    XXXX.XX% XXXX.XX%
13       SURGERY               XXX,XXX X,XXX,XXX  $XX,XXX,XXX  $XXX.XX   *  XXX,XXX X,XXX,XXX  $XXX,XXX,XXX XXX.XX%    $XXX.XX  $X,XXX.XX    XXXX.XX% XXXX.XX%
                                                                         *
14     D & E SERVICES          XXX,XXX X,XXX,XXX  $XX,XXX,XXX  $XXX.XX   *  XXX,XXX X,XXX,XXX  $XXX,XXX,XXX XXX.XX%    $XXX.XX  $X,XXX.XX    XXXX.XX% XXXX.XX%
14     EPSDT                   XXX,XXX X,XXX,XXX  $XX,XXX,XXX  $XXX.XX   *  XXX,XXX X,XXX,XXX  $XXX,XXX,XXX XXX.XX%    $XXX.XX  $X,XXX.XX    XXXX.XX% XXXX.XX%
NA     FAMILY PLANNING         XXX,XXX X,XXX,XXX  $XX,XXX,XXX  $XXX.XX   *  XXX,XXX X,XXX,XXX  $XXX,XXX,XXX XXX.XX%    $XXX.XX  $X,XXX.XX    XXXX.XX% XXXX.XX%
NA     HOME HEALTH SVCS        XXX,XXX X,XXX,XXX  $XX,XXX,XXX  $XXX.XX   *  XXX,XXX X,XXX,XXX  $XXX,XXX,XXX XXX.XX%    $XXX.XX  $X,XXX.XX    XXXX.XX% XXXX.XX%
NA     RURAL HEALTH SVCS       XXX,XXX X,XXX,XXX  $XX,XXX,XXX  $XXX.XX   *  XXX,XXX X,XXX,XXX  $XXX,XXX,XXX XXX.XX%    $XXX.XX  $X,XXX.XX    XXXX.XX% XXXX.XX%
                                                                         *
14     STERILIZATIONS          XXX,XXX X,XXX,XXX  $XX,XXX,XXX  $XXX.XX   *  XXX,XXX X,XXX,XXX  $XXX,XXX,XXX XXX.XX%    $XXX.XX  $X,XXX.XX    XXXX.XX% XXXX.XX%
NA     CLINIC SVCS             XXX,XXX X,XXX,XXX  $XX,XXX,XXX  $XXX.XX   *  XXX,XXX X,XXX,XXX  $XXX,XXX,XXX XXX.XX%    $XXX.XX  $X,XXX.XX    XXXX.XX% XXXX.XX%
NA     HHA-REHAB. SVCS         XXX,XXX X,XXX,XXX  $XX,XXX,XXX  $XXX.XX   *  XXX,XXX X,XXX,XXX  $XXX,XXX,XXX XXX.XX%    $XXX.XX  $X,XXX.XX    XXXX.XX% XXXX.XX%
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WM49-01R                                 CATEGORY OF SERVICE AND LOCATION REPORT                                                    DATE ENDING:  XX/XX/XX
                                                          PART I                                                                    RUN DATE:     XX/XX/XX
                                       EXECUTIVE SUMMARY:  PAYMENTS FOR RATES/PER DIEM                                              PAGE:         3

                            - - - - - - - CURRENT MONTH - - - - - - - * - - - - - - - - - - - - - - - FISCAL YEAR TO DATE - - - - - - - - - - - - - - - - -
                                                                      *
LOCATION                    UNDUP.                            AVG.  $ * UNDUP.                                  PERCENT  AVG.  $                    CHANGE OVER
ANALYSIS                    # OF     DAYS      TOTAL  ADJ.    PER DAY * # OF     DAYS      TOTAL  ADJ.          OF  ALL  PER DAY    AVG $             PREV.  FY
ON PAGE                     RECIPS   OF CARE   EXPENDITURE    OF CARE * RECIPS   OF CARE   EXPENDITURE          RATES   OF CARE   PER RECIP  DAY OF CARE RECIP.
HOSPITAL CARE                                                         *
                                                                      *
  HOSPITAL, GENERAL         XXX,XXX  X,XXX,XXX $XX,XXX,XXX    $XXX.XX * XXX,XXX X,XXX,XXX  $XXX,XXX,XXX         XX.XX%  $XXX.XX  $XX,XXX.XX  XXXX.XX%  XXXX.XX%
  HOSPITAL, MENTAL          XXX,XXX  X,XXX,XXX $XX,XXX,XXX    $XXX.XX * XXX,XXX X,XXX,XXX  $XXX,XXX,XXX         XX.XX%  $XXX.XX  $XX,XXX.XX  XXXX.XX%  XXXX.XX%
  HOSPITAL, T.B.            XXX,XXX  X,XXX,XXX $XX,XXX,XXX    $XXX.XX * XXX,XXX X,XXX,XXX  $XXX,XXX,XXX         XX.XX%  $XXX.XX  $XX,XXX.XX  XXXX.XX%  XXXX.XX%
                                                                      *
                                                                      *
LONG TERM CARE                                                        *
  SNF                       XXX,XXX  X,XXX,XXX $XX,XXX,XXX.   $XXX.XX * XXX,XXX X,XXX,XXX  $XXX,XXX,XXX         XX.XX%  $XXX.XX  $XX,XXX.XX  XXXX.XX%  XXXX.XX%
  ICF                       XXX,XXX  X,XXX,XXX $XX.XXX.XXX    $XXX.XX * XXX,XXX X,XXX,XXX  $XXX,XXX,XXX         XX.XX%  $XXX.XX  $XX,XXX.XX  XXXX.XX%  XXXX.XX%
                                                                      *
  ICF-MR (CRF)              XXX,XXX  X,XXX,XXX $XX,XXX,XXX    $XXX.XX * XXX,XXX X,XXX,XXX  $XXX,XXX,XXX         XX.XX%  $XXX.XX  $XX,XXX.XX  XXXX.XX%  XXXX.XX%
  ICF-MR (STATE)            XXX,XXX  X,XXX,XXX $XX,XXX,XXX    $XXX.XX * XXX,XXX X,XXX,XXX  $XXX,XXX,XXX         XX.XX%  $XXX.XX  $XX,XXX.XX  XXXX.XX%  XXXX.XX%
  ICF-MR (OTHER)            XXX,XXX  X,XXX,XXX $XX,XXX,XXX    $XXX.XX * XXX,XXX X,XXX,XXX  $XXX,XXX,XXX         XX.XX%  $XXX.XX  $XX,XXX.XX  XXXX.XX%  XXXX.XX%
                                                                      *
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WM49-01R

CATEGORY OF SERVICE AND LOCATION REPORT
PART II
LOCATION ANALYSIS

DATE ENDING: XX/XX/XX
RUN DATE: XX/XX/XX
PAGE: 4

	CURRENT MONTH				FISCAL YEAR TO DATE							
	UNDUP. # OF RECIPS	# OF LN ITEMS	TOTAL ADJ. EXPENDITURE	AVG. $ PER LN ITEM	UNDUP. # OF RECIPS	# OF LN ITEMS	TOTAL ADJ. EXPENDITURE	% OF SERVICE OR SUPPLY	AVG. $ PER LN ITEM	AVG $ PER RECIP	CHANGE OVER PREV. FY LN ITEM	CHANGE OVER PREV. FY RECIP.
AUDIOLOGY SERVICES												
TOTAL	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	100.00%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
SNF	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
ICF	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
ICF-MR (CRF)	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
ICF-MR (STATE)	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
ICF-MR (OTHER)	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
HOSPITAL, INPATIENT	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
HOSPITAL, OUTPATIENT	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
CLINIC	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
INDEPENDENT LAB	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
HOME	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
OFFICE	XXX.XXX	X.XXX.XXX	$XX.XXX.XXX	$XXX.XX	XXX.XXX	X.XXX.XXX	$XXX.XXX.XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
CHIROPRACTIC SERVICES												
TOTAL	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	100.00%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
SNF	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
ICF	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
ICF-MR (CRF)	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
ICF-MR (STATE)	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
ICF-MR (OTHER)	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
HOSPITAL, INPATIENT	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
HOSPITAL, OUTPATIENT	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
CLINIC	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
INDEPENDENT LAB	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
HOME	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
OFFICE	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
DENTAL SERVICES												
TOTAL	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	100.00%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
SNF	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
ICF	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
ICF-MR (CRF)	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
ICF-MR (STATE)	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
ICF-MR (OTHER)	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
HOSPITAL, INPATIENT	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
HOSPITAL, OUTPATIENT	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
CLINIC	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
INDEPENDENT LAB	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
HOME	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%
OFFICE	XXX,XXX	X,XXX,XXX	$XX,XXX,XXX	$XXX.XX	XXX,XXX	X,XXX,XXX	$XXX,XXX,XXX	XX.XX%	$XXX.XX	$X,XXX.XX	XXXX.XX%	XXXX.XX%

WM49-01R

CATEGORY OF SERVICE AND LOCATION REPORT
PART II
LOCATION ANALYSIS

DATE ENDING: XX/XX/XX
RUN DATE: XX/XX/XX
PAGE: 5

	CURRENT MONTH				FISCAL YEAR TO DATE							
	UNDUP. # OF RECIPS	# OF LN ITEMS	TOTAL ADJ. EXPENDITURE	AVG. $ PER LN ITEM	UNDUP. # OF RECIPS	# OF LN ITEMS	TOTAL ADJ. EXPENDITURE	% OF SERVICE OR SUPPLY	AVG. $ PER LN ITEM	AVG $ PER RECIP	CHANGE OVER PREV. FY LN ITEM	RECIP.
LAB & XRAY SERVICES												
TOTAL												
SNF												
ICF												
ICF-MR (CRF)												
ICF-MR (STATE)												
ICF-MR (OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												
PSYCHOLOGICAL SERVICES												
TOTAL												
SNF												
ICF												
ICF-MR (CRF)												
ICF-MR (STATE)												
ICF-MR (OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												
NURSING SERVICES												
TOTAL												
SNF												
ICF												
ICF-MR (CRF)												
ICF-MR (STATE)												
ICF-MR (OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												

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WM49-01R                                  CATEGORY OF SERVICE AND LOCATION REPORT                              DATE ENDING:  XX/XX/XX
                                                         PART II                                               RUN DATE:     XX/XX/XX
                                                    LOCATION ANALYSIS                                          PAGE:         6

                  - - - - - - - CURRENT MONTH - - - - - - - * - - -  - - - - - - - - - - - FISCAL YEAR TO DATE - - - - - - - - - - - - - - - -
                                                            *
                  UNDUP.                            AVG. $  *  UNDUP.                               % OF      AVG $                 CHANGE OVER
                  # OF    # OF     TOTAL  ADJ.      PER     *  # OF     # OF     TOTAL  ADJ.    SERVICE OR   PER      AVG $          PREV.  FY
                  RECIPS LN ITEMS  EXPENDITURE    LN ITEM   *  RECIPS  LN ITEMS  EXPENDITURE      SUPPLY   LN ITEM  PER RECIP   LN  ITEM  RECIP.
      ____________________________________________________________________________________________________________________________________________
OPTOMETRIC SERVICES                                         *
               TOTAL                                        *
                                                            *
 SNF                                                        *
 ICF                                                        *
 ICF-MR (CRF)                                               *
 ICF-MR (STATE)                                             *
 ICF-MR (OTHER)                                             *
                                                            *
 HOSPITAL, INPATIENT                                        *
 HOSPITAL, OUTPATIENT                                       *
 CLINIC                                                     *
 INDEPENDENT LAB                                            *
 HOME                                                       *
                                                            *
 OFFICE                                                     *
                                                            *
PHYSICIAN SERVICES                                          *
               TOTAL                                        *
                                                            *
 SNF                                                        *
 ICF                                                        *
 ICF-MR (CRF)                                               *
 ICF-MR (STATE)                                             *
 ICF-MR (OTHER)                                             *
                                                            *
 HOSPITAL, INPATIENT                                        *
 HOSPITAL, OUTPATIENT                                       *
 CLINIC                                                     *
 INDEPENDENT LAB                                            *
 HOME                                                       *
                                                            *
 OFFICE                                                     *
                                                            *
PODIATRY SERVICES                                           *
               TOTAL                                        *
                                                            *
 SNF                                                        *
 ICF                                                        *
 ICF-MR (CRF)                                               *
 ICF-MR (STATE)                                             *
 ICF-MR (OTHER)                                             *
                                                            *
 HOSPITAL, INPATIENT                                        *
 HOSPITAL, OUTPATIENT                                       *
 CLINIC                                                     *
 INDEPENDENT LAB                                            *
 HOME                                                       *
                                                            *
 OFFICE                                                     *
                                                            *
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CATEGORY OF SERVICE AND LOCATION REPORT

	CURRENT MONTH				FISCAL YEAR TO DATE							
	UNDUP. # OF RECIPS	# OF LN ITEMS (CLAIMS)	TOTAL ADJ. EXPENDITURE	AVG. $ PER LN ITEM (CLAIM)	UNDUP. # OF RECIPS	# OF LN ITEMS (CLAIMS)	TOTAL ADJ. EXPENDITURE	% OF SERVICE OR SUPPLY	AVG. $ PER LN ITEM (CLAIM)	AVG $ PER RECIP	CHANGE OVER PREV. FY (CLAIM)	CHANGE OVER PREV. FY RECIP.
OPTICIANS, DISPENSING												
TOTAL												
SNF												
ICF												
ICF-MR(CRF)												
ICF-MR(STATE)												
ICF-MR(OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												
THERAPY-OCCUPATIONAL												
TOTAL												
SNF												
ICF												
ICF-MR(CRF)												
ICF-MR(STATE)												
ICF-MR(OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												
THERAPY-PHYSICAL												
TOTAL												
SNF												
ICF												
ICF-MR(CRF)												
ICF-MR(STATE)												
ICF-MR(OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												

WM49-01R

CATEGORY OF SERVICE AND LOCATION REPORT

DATE ENDING: XX/XX/XX
RUN DATE: XX/XX/XX
PAGE: 8

	CURRENT MONTH				FISCAL YEAR TO DATE							
	UNDUP. # OF RECIPS	# OF LN ITEMS (CLAIMS)	TOTAL ADJ. EXPENDITURE	AVG. $ PER LN ITEM (CLAIM)	UNDUP. # OF RECIPS	# OF LN ITEMS (CLAIMS)	TOTAL ADJ. EXPENDITURE	% OF SERVICE OR SUPPLY	AVG. $ PER LN ITEM (CLAIM)	AVG $ PER RECIP	CHANGE OVER PREV. FY (CLAIM)	CHANGE OVER PREV. FY RECIP.
THERAPY-RESPITATORY												
TOTAL												
SNF												
ICF												
ICF-MR(CRF)												
ICF-MR(STATE)												
ICF-MR(OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												
THERAPY-SPEECH												
TOTAL												
SNF												
ICF												
ICF-MR(CRF)												
ICF-MR(STATE)												
ICF-MR(OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												
TRANSPORTATION-AMBULANCE												
SNF												
ICF												
ICF-MR(CRF)												
ICF-MR(STATE)												
ICF-MR(OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												

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WM49-01R                               CATEGORY OF SERVICE AND LOCATION REPORT                                 DATE ENDING:  XX/XX/XX
                                                                                                                RUN DATE:     XX/XX/XX
                                                                                                                PAGE:         9

                      - - - - - - - - CURRENT MONTH - - - - - - - * - - - - - - - - - - - - - - - - FISCAL YEAR TO DATE - - - - - - - - - - - - - - - - -
                                                          AVG. $  *                                                      AVG. $
                      UNDUP.     # OF                      PER    *  UNDUP.     # OF                          % OF        PER                   CHANGE OVER
                       # OF    LN  ITEMS    TOTAL  ADJ.  LN ITEM  *   # OF    LN  ITEMS   TOTAL  ADJ.   SERVICE OR  LN ITEM     AVG $          PREV.  FY
                      RECIPS   (CLAIMS)   EXPENDITURE   (CLAIM)   *  RECIPS   (CLAIMS)   EXPENDITURE     SUPPLY      (CLAIM)  PER RECIP    (CLAIM)   RECIP.
----------------------------------------------------------------------------------------------------------------------------------------------------------------
TRANSPORTATION-AMBULANCE VANS                                     *
              TOTAL                                               *
   SNF                                                            *
   ICF                                                            *
   ICF-MR(CRF)                                                    *
   ICF-MR(STATE)                                                  *
   ICF-MR(OTHER)                                                  *
                                                                  *
   HOSPITAL, INPATIENT                                            *
   HOSPITAL, OUTPATIENT                                           *
   CLINIC                                                         *
   INDEPENDENT LAB                                                *
   HOME                                                           *
                                                                  *
   OFFICE                                                         *
TRANSPORTATION-CHAIRLANCE                                         *
              TOTAL                                               *
   SNF                                                            *
   ICF                                                            *
   ICF-MR(CRF)                                                    *
   ICF-MR(STATE)                                                  *
   ICF-MR(OTHER)                                                  *
                                                                  *
   HOSPITAL, INPATIENT                                            *
   HOSPITAL, OUTPATIENT                                           *
   CLINIC                                                         *
   INDEPENDENT LAB                                                *
   HOME                                                           *
                                                                  *
   OFFICE                                                         *
TRANSPORTATION-INVALID COACH                                      *
              TOTAL                                               *
   SNF                                                            *
   ICF                                                            *
   ICF-MR(CRF)                                                    *
   ICF-MR(STATE)                                                  *
   ICF-MR(OTHER)                                                  *
                                                                  *
   HOSPITAL, INPATIENT                                            *
   HOSPITAL, OUTPATIENT                                           *
   CLINIC                                                         *
   INDEPENDENT LAB                                                *
   HOME                                                           *
                                                                  *
   OFFICE                                                         *
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WM49-01R                              CATEGORY OF SERVICE AND LOCATION REPORT
                                                                                                              DATE ENDING:  XX/XX/XX
                                                                                                              RUN DATE:     XX/XX/XX
                                                                                                              PAGE:         10

                          - - - - - - - CURRENT MONTH - - - - - - -*- - - - - - - - - - - - - - - FISCAL YEAR TO DATE - - - - - - - - - - - - - - - -
                                                            AVG. $ *                                                 AVG. $
                          UNDUP.    # OF                     PER   *  UNDUP.    # OF                        % OF        PER                    CHANGE OVER
                          # OF    LN  ITEMS   TOTAL  ADJ.  LN ITEM *  # OF    LN  ITEMS  TOTAL  ADJ.  SERVICE OR  LN ITEM    AVG $          PREV.  FY
                          RECIPS  (CLAIMS)   EXPENDITURE   (CLAIM) *  RECIPS  (CLAIMS)  EXPENDITURE     SUPPLY    (CLAIM)  PER RECIP     (CLAIM)   RECIP.
TRANSPORTATION-TAXI                                                *
                 TOTAL                                             *
  SNF                                                              *
  ICF                                                              *
  ICF-MR(CRF)                                                      *
  ICF-MR(STATE)                                                    *
  ICF-MR(OTHER)                                                    *
                                                                   *
  HOSPITAL, INPATIENT                                              *
  HOSPITAL, OUTPATIENT                                             *
  CLINIC                                                           *
  INDEPENDENT LAB                                                  *
  HOME                                                             *
                                                                   *
  OFFICE                                                           *
TRANSPORTATION-INDIVIDUAL PRACTITIONER                             *
                 TOTAL                                             *
  SNF                                                              *
  ICF                                                              *
  ICF-MR(CRF)                                                      *
  ICF-MR(STATE)                                                    *
  ICF-MR(OTHER)                                                    *
                                                                   *
  HOSPITAL, INPATIENT                                              *
  HOSPITAL, OUTPATIENT                                             *
  CLINIC                                                           *
  INDEPENDENT LAB                                                  *
  HOME                                                             *
                                                                   *
  OFFICE                                                           *
TRANSPORTATION-MISC.                                               *
                 TOTAL                                             *
  SNF                                                              *
  ICF                                                              *
  ICF-MR(CRF)                                                      *
  ICF-MR(STATE)                                                    *
  ICF-MR(OTHER)                                                    *
                                                                   *
  HOSPITAL, INPATIENT                                              *
  HOSPITAL, OUTPATIENT                                             *
  CLINIC                                                           *
  INDEPENDENT LAB                                                  *
  HOME                                                             *
                                                                   *
  OFFICE                                                           *
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WM49-01R                              CATEGORY OF SERVICE AND LOCATION REPORT                              DATE ENDING:  XX/XX/XX
                                                                                                           RUN DATE:     XX/XX/XX
                                                                                                           PAGE:         11

                    - - - - - - - CURRENT MONTH - - - - - - - *- - - - - - - - - - - - - - - FISCAL YEAR TO DATE - - - - - - - - - - - - - - - - -
                                                        AVG. $ *                                                   AVG. $
                    UNDUP.    # OF                         PER *  UNDUP.    # OF                          % OF        PER                    CHANGE OVER
                    # OF   LN  ITEMS   TOTAL  ADJ.    LN ITEM  *  # OF   LN  ITEMS   TOTAL  ADJ.   SERVICE OR  LN ITEM     AVG $          PREV.  FY
                    RECIPS  (CLAIMS)  EXPENDITURE    (CLAIM)   *  RECIPS   (CLAIMS)  EXPENDITURE     SUPPLY     (CLAIM)   PER RECIP    (CLAIM)   RECIP.
-----------------------------------------------------------------------------------------------------------------------------------------------------
OTHER SERVICES                                                 *
           TOTAL                                               *
   SNF                                                         *
   ICF                                                         *
   ICF-MR(CRF)                                                 *
   ICF-MR(STATE)                                               *
   ICF-MR(OTHER)                                               *
                                                               *
   HOSPITAL, INPATIENT                                         *
   HOSPITAL, OUTPATIENT                                        *
   CLINIC                                                      *
   INDEPENDENT LAB                                             *
   HOME                                                        *
                                                               *
   OFFICE                                                      *
                                                               *
DRUGS, LEGEND                                                  *
           TOTAL                                               *
   SNF                                                         *
   ICF                                                         *
   ICF-MR(CRF)                                                 *
   ICF-MR(STATE)                                               *
   ICF-MR(OTHER)                                               *
                                                               *
   HOSPITAL, INPATIENT                                         *
   HOSPITAL, OUTPATIENT                                        *
   CLINIC                                                      *
   INDEPENDENT LAB                                             *
   HOME                                                        *
                                                               *
   OFFICE                                                      *
                                                               *
DRUGS, NON-LEGEND                                              *
           TOTAL                                               *
   SNF                                                         *
   ICF                                                         *
   ICF-MR(CRF)                                                 *
   ICF-MR(STATE)                                               *
   ICF-MR(OTHER)                                               *
                                                               *
   HOSPITAL, INPATIENT                                         *
   HOSPITAL, OUTPATIENT                                        *
   CLINIC                                                      *
   INDEPENDENT LAB                                             *
   HOME                                                        *
                                                               *
   OFFICE                                                      *
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WM49-01R

CATEGORY OF SERVICE AND LOCATION REPORT

DATE ENDING: XX/XX/XX
RUN DATE: XX/XX/XX
PAGE: 12

	CURRENT MONTH				FISCAL YEAR TO DATE							
	UNDUP. # OF RECIPS	# OF LN ITEMS (CLAIMS)	TOTAL ADJ. EXPENDITURE	AVG. $ PER LN ITEM (CLAIM)	UNDUP. # OF RECIPS	# OF LN ITEMS (CLAIMS)	TOTAL ADJ. EXPENDITURE	% OF SERVICE OR SUPPLY	AVG. $ PER LN ITEM (CLAIM)	AVG $ PER RECIP	CHANGE OVER PREV. FY (CLAIM)	CHANGE OVER PREV. FY RECIP.
DURABLE MEDICAL EQUIPMENT												
TOTAL												
SNF												
ICF												
ICF-MR(CRF)												
ICF-MR(STATE)												
ICF-MR(OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												
PROSTHETIC DEVICES												
TOTAL												
SNF												
ICF												
ICF-MR(CRF)												
ICF-MR(STATE)												
ICF-MR(OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												
HEARING AIDS AND BATTERIES												
TOTAL												
SNF												
ICF												
ICF-MR(CRF)												
ICF-MR(STATE)												
ICF-MR(OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												

WM49-01R

CATEGORY OF SERVICE AND LOCATION REPORT

DATE ENDING: XX/XX/XX
RUN DATE: XX/XX/XX
PAGE: 13

	CURRENT MONTH				FISCAL YEAR TO DATE							
	UNDUP. # OF RECIPS	# OF LN ITEMS (CLAIMS)	TOTAL ADJ. EXPENDITURE	AVG. $ PER LN ITEM (CLAIM)	UNDUP. # OF RECIPS	# OF LN ITEMS (CLAIMS)	TOTAL ADJ. EXPENDITURE	% OF SERVICE OR SUPPLY	AVG. $ PER LN ITEM (CLAIM)	AVG $ PER RECIP	CHANGE OVER PREV. FY (CLAIM)	CHANGE OVER PREV. FY RECIP.
OTHER SUPPLIES												
TOTAL												
SNF												
ICF												
ICF-MR(CRF)												
ICF-MR(STATE)												
ICF-MR(OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												
PHYSICIAN, ANESTHESIA												
TOTAL												
SNF												
ICF												
ICF-MR(CRF)												
ICF-MR(STATE)												
ICF-MR(OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												
PHYSICIAN, SURGERY												
TOTAL												
SNF												
ICF												
ICF-MR(CRF)												
ICF-MR(STATE)												
ICF-MR(OTHER)												
HOSPITAL, INPATIENT												
HOSPITAL, OUTPATIENT												
CLINIC												
INDEPENDENT LAB												
HOME												
OFFICE												

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WM49-01R                              CATEGORY OF SERVICE AND LOCATION REPORT
                                                                                                        DATE ENDING:  XX/XX/XX
                                                                                                        RUN DATE:     XX/XX/XX
                                                                                                        PAGE:         14

                              - - - - - - - CURRENT MONTH - - - - - - - * - - -   - - - - - - - - - - - FISCAL YEAR TO DATE - - - - - - - - - - - - - - -
                                                                AVG. $  *                                                  AVG. $
                              UNDUP.    # OF                      PER   *                                      % OF        PER                    CHANGE OVER
                               # OF   LN  ITEMS   TOTAL  ADJ.  LN ITEM  *   UNDUP.    # OF     TOTAL  ADJ.  SERVICE OR  LN ITEM     AVG $          PREV.  FY
                              RECIPS   (CLAIMS)  EXPENDITURE   (CLAIM)  *   # OF    LN  ITEMS  EXPENDITURE    SUPPLY     (CLAIM)   PER RECIP   (CLAIM)   RECIP.
_____________________________________________________________________________________________________________________________________________________________
DIAGNOSIS & EVALUATION SERVICES                                         *
                TOTAL                                                   *
  SNF                                                                   *
  ICF                                                                   *
  ICF-MR(CRF)                                                           *
  ICF-MR(STATE)                                                         *
  ICF-MR(OTHER)                                                         *
                                                                        *
  HOSPITAL, INPATIENT                                                   *
  HOSPITAL, OUTPATIENT                                                  *
  CLINIC                                                                *
  INDEPENDENT LAB                                                       *
  HOME                                                                  *
                                                                        *
  OFFICE                                                                *
                                                                        *
EPSDT                                                                   *
                TOTAL                                                   *
  SNF                                                                   *
  ICF                                                                   *
  ICF-MR(CRF)                                                           *
  ICF-MR(STATE)                                                         *
  ICF-MR(OTHER)                                                         *
                                                                        *
  HOSPITAL, INPATIENT                                                   *
  HOSPITAL, OUTPATIENT                                                  *
  CLINIC                                                                *
  INDEPENDENT LAB                                                       *
  HOME                                                                  *
                                                                        *
  OFFICE                                                                *
                                                                        *
STERILIZATIONS                                                          *
                TOTAL                                                   *
  SNF                                                                   *
  ICF                                                                   *
  ICF-MR(CRF)                                                           *
  ICF-MR(STATE)                                                         *
  ICF-MR(OTHER)                                                         *
                                                                        *
  HOSPITAL, INPATIENT                                                   *
  HOSPITAL, OUTPATIENT                                                  *
  CLINIC                                                                *
  INDEPENDENT LAB                                                       *
  HOME                                                                  *
                                                                        *
  OFFICE                                                                *
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ATTACHMENT C

CLAIMS THRUPUT REPORT

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WH06-08R                          INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM     SAMPLE    DATE 06/10/80
                                     BILL & CLAIM PROCESSING THRUPUT ANALYSIS                  PAGE   1
TYPE OF BILL
 LAST SVC DATE-CHECK DATE 15   DAYS   30   DAYS   45   DAYS   60   DAYS   90   DAYS  180  DAYS  365  DAYS  365  PLUS   AVG. DAYS

CLEAN BILLS (UNIQUE ICN)
 INPATIENT HOSPITAL       37.2050%   77.4838%   87.5085%   90.4754%   93.6346%   97.8582%   99.7777%  100.0000%
                             8,703     18,125     20,470     21,164     21,903     22,891     23,340     23,392          32
 DRUG (SAME AS CLEAN CLAIMS 6.2965%  45.8265%   75.2591%   87.1767%   94.5806%   98.3499%   99.8536%  100.0000%
                            17,767    129,310    212,361    245,939    266,881    277,517    281,760    282,173          42
 MEDICAL                     .0376%  18.3031%   54.9045%   74.9302%   89.3022%   96.9403%   99.7743%  100.0000%
                                24     11,677     35,028     47,804     56,973     61,846     63,654     63,798          56
 OUTPATIENT HOSPITAL         .1406%  29.3224%   53.3414%   67.0350%   83.2932%   94.8373%   99.4509%  100.0000%
                                21      4,379      7,966     10,011     12,439     14,163     14,852     14,934          64
 MEDICARE CROSSOVER          .0000%   7.4562%   41.9500%   63.0108%   83.2483%   94.5161%   99.1596%  100.0000%
                                 0      1.739      9,784     14,696     19,416     22,044     23,127     23,323          70
                    TOTAL   6.5048%  40.5353%   70.0675%   83.3206%   92.6382%   97.7531%   99.7824%  100.0000%
                            26,515    165.230    285,609    339,664    377,612    398,461    406,733    407,620

ALL BILLS (UNIQUE ICN)'
 INPATIENT HOSPITAL       35.0472%   74.6980%   85.0532%   88.4367%   92.0690%   97.0058%   99.3498%  100.0000%
                             8,732     18.611     21,191     22,034     22,939     24,169     24,753     24,915          36
 DRUG (SAME AS ALL CLAIMS)  6.0481%  44.3826%   73.4986%   85.8085%   93.5696%   97.8319%   99.6730%  100.0000%
                            17,831    130,848    216,687    252,979    275,860    288,426    293,854    294,818          44
 MEDICAL                     .0354%  16.8885%   52.0252%   72.2915%   87.1605%   95.7046%   99.1984%  100.0000%
                                25     11,925     36,735     51,045     61,544     67,577     70,044     70,610          52
 OUTPATIENT HOSPITAL         .1445%  26.3997%   50.2745%   64.1821%   80.5686%   92.8468%   98.2030%  100.0000%
                                25      4,569      8,701     11,108     13,944     16,069     16,996     17,307          72
 MEDICARE CROSSOVER          .0000%   7.3306%   41.0268%   62.0303%   82.3216%   93.8698%   98.6995%  100.0000%
                                 0      1,832     10,253     15,502     20,573     23,459     24,666     24,991          73
                    TOTAL   6.1513%  38.7016%   67.8546%   81.5152%   91.2674%   97.0088%   99.4619%  100.0000%
                            26,613    167,785    293,567    352,668    394,860    419,700    430,313    432,641

CLEAN CLAIMS (UNIQUE LINE ITEM)
 INPATIENT HOSPITAL       26.0560%   61.4501%   77.8041%   82.9158%   88.1029%   96.3251%   99.6015%  100.0000%
                            12,096     28,527     36,119     38,492     40,900     44,717     46,238     46,423          44
 DRUG                       6.2965%  45.8265%   75.2591%   87.1767%   94.5806%   98.3499%   99.8536%  100.0000%
                            17,767    129,310    212,361    245,989    266,881    277,517    281,760    282,173          42
 MEDICAL                     .0373%  15.2968%   48.5632%   68.6642%   85.7523%   95.9463%   99.6882%  100.0000%
                                45     18,445     58,558     82,796    103,401    115,693    120,205    120,581          62
 OUTPATIENT HOSPITAL         .1027%  28.3139%   53.9690%   68.1868%   82.8877%   94.6712%   99.4219%  100.0000%
                                27      7,444     14,189     17,927     21,792     24,890     26,139     26,291          64
 MEDICARE CROSSOVER          .0000%   8.1929%   39.7369%   61.1848%   81.9461%   94.2252%   98.7219%  100.0000%
                                 0      4,391     21,297     32,792     43,919     50,500     52,910     53,595          72
                    TOTAL   5.6581%  35.5566%   64.7416%   79.0068%   90.1392%   97.0238%   99.6577%  100.0000%
                            29,935    188.117    342,524    417,996    476,893    513,317    527,252    529,063

ALL CLAIMS (UNIQUE LINE-ITEM)
 INPATIENT HOSPITAL       23.8000%   57.9252%   74.4929%   80.0474%   85.7529%   95.0687%   99.0573%  100.0000%
                            12,143     29,554     38,007     40,841     43,752     48,505     50,540     51,021          56
 DRUG                       6.0481%  44.3826%   73.4986%   85.8085%   93.5696%   97.8319%   99.6730%  100.0000%
                            17,831    130,848    216,687    252,979    275,860    288,426    293,854    294,818          44
 MEDICAL                     .0336%  14.0177%   45.6697%   65.7415%   83.1593%   94.4908%   79.1195%  100.0000%
                                46     19,167     62,446     89,891    113,707    129,201    135,530    136,734          68
 OUTPATIENT HOSPITAL         .1016%  25.3072%   50.5685%   65.1604%   80.0963%   92.5582%   98.0634%  100.0000%
                                31      7,723     15,432     19,885     24,443     28,246     29,926     30,517          73
 MEDICARE CROSSOVER         6.8463%  39.7030%   67.4434%   80.2853%   90.1058%   96.6219%   99.3506%  100.0000%
                            30,005    174,005    295,582    351,864    394,904    423,462    435,421    438,267          51
                    TOTAL   6.3127%  37.9770%   66.0272%   79.4087%   89.6263%   96.4769%   99.3603%  100.0000%
                            60,056    361,297    628,154    755,460    852,666    917,840    945,271    951,357
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W7106-08R                        INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                                  DATE 06/10/80
                                   BILL & CLAIM PROCESSING THRUPUT ANALYSIS                                      PAGE    2
TYPE OF BILL
 LAST SVC DATE-ADJ DATE     15    DAYS    30    DAYS    45    DAYS    60    DAYS    90    DAYS   180  DAYS   365  DAYS   365  PLUS   AVG. DAYS

CLEAN BILLS (UNIQUE ICN)
 INPATIENT HOSPITAL          64.2998%      82.0195%      89.6888%      91.2833%      94.0749%     97.9523%     99.7948%   100.0000%
                               15,041        19,106        20,980        21,353        22,006       22,913       23,344      23,392          26
 DRUG (SAME AS CLEAN CLAIMS  14.3805%      62.3600%      82.4625%      89.9257%      95.1473%     98.4602%     99.8621%   100.0000%
                               40,578       175,963       232,687       253,746       268,480      277,828      281,784     282,173          35
 MEDICAL                       .7336%      35.6673%      66.2027%      80.5652%      90.5028%     97.1708%     99.8072%   100.0000%
                                  468        22,755        42,236        51,399        57,739       61,993       63,675      63,798          50
 OUTPATIENT HOSPITAL          5.7855%      40.5049%      60.2920%      72.2178%      84.9136%     95.2190%     99.5045%   100.0000%
                                  864         6,049         9,004        10,785        12,681       14,220       14,860      14,934          57
 MEDICARE CROSSOVER            .2744%      24.8253%      54.5813%      70.6770%      85.4907%     94.8849%     99.2454%   100.0000%
                                   64         5,790        12,730        16,484        19,939       22,130       23,147      23,323          62
                     TOTAL   13.9873%      56.3621%      77.9248%      86.7884%      93.4314%     97.9059%     99.8013%   100.0000%
                               57,015       229,743       317,637       353,767       380,845      399,084      406,810     407,620

ALL BILLS (UNIQUE ICN):
 INPATIENT HOSPITAL          61.9025%      79.3498%      87.4614%      89.3438%      92.5547%     97.1102%     99.3699%   100.0000%
                               15,423        19,770        21,791        22,260        23,060       24,195       24,759      24,915          30
 DRUG (SAME AS ALL CLAIMS)   13.8933%      60.3956%      80.9153%      88.6391%      94.1947%     97.9642%     99.6852%   100.0000%
                               40,960       178,057       238,553       261,324       277,703      288,816      293,890     294,818          38
 MEDICAL                       .6784%      33.1384%      63.4924%      78.1008%      88.4379%     95.9907%     99.2437%   100.0000%
                                  479        23,399        44,832        55,147        62,446       67,779       70,076      70,610          55
 OUTPATIENT HOSPITAL          5.0962%      37.3028%      57.2138%      69.3650%      82.1980%     93.2455%     98.2550%   100.0000%
                                  882         6,456         9,902        12,005        14,226       16,138       17,005      17,307          66
 MEDICARE CROSSOVER            .2721%      24.1367%      53.6673%      69.6171%      84.5784%     94.2459%     98.7996%   100.0000%
                                   68         6,032        13,412        17,398        21,137       23,553       24,691      24,991          65
                     TOTAL   13.3626%      54.0203%      75.9267%      85.0899%      92.1253%     97.1894%     99.4866%   100.0000%
                               57,812       233,714       328,490       368,134       398,572      420,481      430,420     432,641

CLEAN CLAIMS (UNIQUE LINE ITEM)
 INPATIENT HOSPITAL          47.1770%      70.4651%      81.3713%      84.5141%      88.9904%     96.6137%     99.6273%   100.0000%
                               21,901        32,712        37,775        39,234        41,312       44,851       46,250      46,423          37
 DRUG                        14.3805%      62.3600%      82.4625%      89.9257%      95.1473%     98.4602%     99.8621%   100.0000%
                               40,578       175,963       232,687       253,746       268,480      277,828      281,784     282,173          35
 MEDICAL                       .5731%      30.7262%      59.3775%      74.8941%      87.2882%     96.2482%     99.7205%   100.0000%
                                  691        37,050        71,598        90,308       105,253      116,057      120,244     120,581          56
 OUTPATIENT HOSPITAL          5.3326%      39.9680%      61.2415%      72.7663%      84.5270%     95.0629%     99.4903%   100.0000%
                                1,402        10,508        16,101        19,131        22,223       24,993       26,157      26,291          58
 MEDICARE CROSSOVER            .4385%      23.5302%      52.5553%      68.8590%      84.4426%     94.6226%     98.8693%   100.0000%
                                  235        12,611        28,167        36,905        45,257       50,713       52,989      53,595          65
                     TOTAL   12.2494%      50.8151%      73.0212%      83.0381%      91.2037%     97.2364%     99.6902%   100.0000%
                               64,807       268,844       386,328       439,324       482,525      514,442      527,424     529,063

ALL CLAIMS (UNIQUE LINE-ITEM)
 INPATIENT HOSPITAL          44.4503%      66.9352%      78.1913%      81.7154%      86.6780%     95.3043%     99.0327%   100.0000%
                               22,679        34,151        39,894        41,692        44,224       48,666       50,553      51,021          44
 DRUG                        13.8933%      60.3956%      80.9153%      88.6391%      94.1947%     97.9642%     99.6852%   100.0000%
                               40,960       178,057       238,553       261,324       277,703      288,816      293,890     294,818          38
 MEDICAL                       .5156%      28.3214%      56.4870%      72.0231%      84.8011%     94.8630%     99.1641%   100.0000%
                                  705        38,725        77,237        98,480       115,952      129,710      135,591     136,734          62
 OUTPATIENT HOSPITAL          4.6630%      36.5108%      57.8137%      69.8496%      81.7053%     92.9646%     98.1256%   100.0000%
                                1,423        11,142        17,643        21,316        24,934       28,370       29,945      30,517          66
 MEDICARE CROSSOVER          14.9197%      54.5350%      75.1017%      83.7636%      91.0831%     96.8337%     99.3853%   100.0000%
                               65,388       239,009       329,146       367,103       399,187      424,390      435,573     438,267          44
                     TOTAL   13.7861%      52.6704%      73.8391%      83.0309%      90.6074%     96.6989%     99.3898%   100.0000%
                              131,155       501,084       702,473       789,920       862,000      919,952      945,552     951,357
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WM06-00R                           INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                                  DATE 06/10/80
                                     BILL & CLAIM PROCESSING THRUPUT ANALYSIS                                      PAGE    3
TYPE OF BILL
 LAST SVC DATE-RCPT DATE   15   DAYS   30   DAYS   45   DAYS   60   DAYS   90   DAYS  180  DAYS  365  DAYS  365  PLUS  AVG. DAYS

CLEAN BILLS (UNIQUE ICN)
 INPATIENT HOSPITAL       76.9024%    80.1669%    90.8516%    92.2495%    94.7461%    98.2045%    99.8376%   100.0000%
                           17,989      20,624      21,252      21,579      22,163      22,972      23,354      23,392          20
 DRUG (SAME AS CLEAN CLAIMS 54.2242%  80.5350%    89.1531%    93.0893%    95.9170%    98.6646%    99.8809%   100.0000%
                          153,006     227,248     251,566     262,673     270,652     278,405     281,837     282,173          25
 MEDICAL                  32.4571%    67.7216%    81.2768%    87.6093%    92.7537%    97.6567%    99.8777%   100.0000%
                           20,707      43,205      51,653      55,893      59,175      62,303      63,720      63,798          35
 OUTPATIENT HOSPITAL      32.8780%    56.9573%    69.0036%    78.1170%    86.7818%    95.8350%    99.6317%   100.0000%
                            4,910       8,506      10,305      11,666      12,960      14,312      14,879      14,934          47
 MEDICARE CROSSOVER        4.3476%    41.3069%    63.1651%    75.7450%    86.8070%    95.1078%    99.3226%   100.0000%
                            1,014       9,634      14,732      17,666      20,246      22,182      23,165      23,323          56
                   TOTAL  48.4829%    75.8591%    85.7927%    90.6425%    94.4988%    98.1733%    99.8369%   100.0000%
                          197,626     309,217     349,708     369,477     385,196     400,174     406,955     407,620

ALL BILLS (UNIQUE ICN)'
 INPATIENT HOSPITAL       74.6498%    85.9001%    88.8702%    90.5037%    93.3735%    97.4032%    99.4341%   100.0000%
                           18,599      21,402      22,142      22,549      23,264      24,268      24,774      24,915          24
 DRUG (SAME AS ALL CLAIMS) 53.2702%   79.2787%    87.9719%    92.0202%    95.0905%    98.2169%    99.7127%   100.0000%
                          157,050     233,728     259,357     271,292     280,344     289,561     293,971     294,818          27
 MEDICAL                  31.2590%    65.6918%    79.1347%    85.5729%    90.9772%    96.5982%    99.3471%   100.0000%
                           22,072      46,385      55,877      60,423      64,239      68,208      70,149      70,610          40
 OUTPATIENT HOSPITAL      31.4439%    54.7524%    66.6956%    75.7555%    84.3011%    93.9735%    98.4457%   100.0000%
                            5,442       9,476      11,543      13,111      14,590      16,264      17,038      17,307          55
 MEDICARE CROSSOVER        4.3216%    40.5626%    62.2904%    74.7909%    85.9269%    94.4900%    98.8876%   100.0000%
                            1,080      10,137      15,567      18,691      21,474      23,614      24,713      24,991          59
                   TOTAL  47.2084%    74.2251%    84.2468%    89.2347%    93.3594%    97.5208%    99.5386%   100.0000%
                          204,243     321,128     364,486     386,066     403,911     421,915     430,645     432,641

CLEAN CLAIMS (UNIQUE LINE ITEM)
 INPATIENT HOSPITAL       66.3098%    80.0336%    83.8744%    86.4851%    90.5543%    97.0618%    99.6920%   100.0000%
                           30,783      37,154      38,937      40,149      42,038      45,059      46,280      46,423          29
 DRUG                     54.2242%    80.5350%    89.1531%    93.0893%    95.9170%    98.6646%    99.8809%   100.0000%
                          153,006     227,248     251,566     262,673     270,652     278,405     281,837     282,173          25
 MEDICAL                  30.2577%    62.4394%    76.7973%    84.1293%    90.5723%    96.9755%    99.8350%   100.0000%
                           36,485      75,290      92,603     101,444     109,213     116,934     120,382     120,501          40
 OUTPATIENT HOSPITAL      32.5853%    57.9552%    70.1761%    78.0039%    86.4897%    95.6943%    99.6158%   100.0000%
                            8,567      15,237      18,450      20,508      22,739      25,159      26,190      26,291          47
 MEDICARE CROSSOVER        5.4539%    39.6716%    61.6494%    74.3745%    86.1162%    94.8820%    98.9551%   100.0000%
                            2,923      21,262      33,041      39,861      46,154      50,852      53,035      53,595          58
                   TOTAL  43.8065%    71.1051%    82.1447%    87.8222%    92.7670%    97.6082%    99.7469%   100.0000%
                          231,764     376,191     434,597     464,635     490,796     516,409     527,724     529,063

ALL CLAIMS (UNIQUE LINE-ITEM)
 INPATIENT HOSPITAL       63.2916%    76.8821%    81.1078%    84.0085%    88.4401%    95.9272%    99.1807%   100.0000%
                           32,292      39,226      41,382      42,862      45,123      48,943      50,603      51,021          35
 DRUG                     53.2702%    79.2787%    87.9719%    92.0202%    95.0905%    98.2169%    99.7127%   100.0000%
                          157,050     233,728     259,357     271,292     280,344     289,561     293,971     294,818          27
 MEDICAL                  28.9972%    60.2337%    74.2910%    81.7054%    88.4725%    95.7809%    99.3191%   100.0000%
                           39,649      82,360     101,581     111,719     120,972     130,965     135,803     136,734          45
 OUTPATIENT HOSPITAL      30.9401%    55.5428%    67.6770%    75.5440%    83.8044%    93.7150%    98.3124%   100.0000%
                            9,442      16,950      20,653      23,054      25,595      28,599      30,002      30,517          55
 MEDICARE CROSSOVER       46.2574%    71.9361%    82.1009%    87.4722%    92.2732%    97.1542%    99.4449%   100.0000%
                          202,731     315,272     359,821     383,362     404,403     425,795     435,834     438,267          34
                   TOTAL  46.3721%    72.2690%    82.2818%    87.4844%    92.1254%    97.1100%    99.4593%   100.0000%
                          441,164     607,536     782,794     832,289     876,441     923,863     946,213     951,357
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WM06-08R                                  INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                              DATE 06/10/80
                                            BILL & CLAIM PROCESSING THRUPUT ANALYSIS                                  PAGE    4
~~TYPE-OF BILL~~
 LAST SVC DATE-BILL DATE   15    DAYS   30    DAYS   45    DAYS   60    DAYS   90    DAYS   180  DAYS   365  DAYS   365  PLUS   AVG. DAYS

CLEAN BILLS (UNIQUE ICN)
 INPATIENT HOSPITAL        85.9225%     91.0311%     92.4590%     93.7500%     95.7122%     98.4396%     99.8547%    100.0000%
                             20,099       21,294       21,628       21,930       22,309       23,027       23,358       23,392          16
 DRUG (SAME AS CLEAN CLAIMS 78.6414%    90.3197%     93.8026%     95.5057%     96.9846%     98.9462%     99.8997%    100.0000%
                            218,653      251,123      260,807      265,542      269,654      275,108      277,759      278,038          14
 MEDICAL                   70.0929%     83.8152%     89.6443%     92.1320%     94.9964%     98.3410%     99.8933%    100.0000%
                             44,659       53,402       57,116       58,701       60,526       62,657       63,646       63,714          20
 OUTPATIENT HOSPITAL       45.3628%     63.3396%     73.4419%     81.2963%     88.3766%     96.3454%     99.6433%    100.0000%
                              6,740        9,411       10,912       12,079       13,131       14,315       14,805       14,858          41
 MEDICARE CROSSOVER         4.3476%     41.3069%     63.1651%     75.7450%     86.8070%     95.1078%     99.3226%    100.0000%
                              1,014        9,634       14,732       17,666       20,246       22,182       23,165       23,323          56
                    TOTAL  72.1912%     85.5052%     90.5461%     93.2047%     95.6911%     98.5034%     99.8532%    100.0000%
                            291,165      344,864      365,195      375,918      305,946      397,289      402,733      403,325

ALL BILLS (UNIQUE ICN)
 INPATIENT HOSPITAL        83.8052%     89.1511%     90.8569%     92.3660%     94.5695%     97.7483%     99.5143%    100.0000%
                             20,900       22,212       22,637       23,013       23,562       24,354       24,794       24,915          18
 DRUG (SAME AS ALL CLAIMS) 77.6251%     89.3036%     92.9226%     94.7392%     96.3809%     98.6169%     99.7772%    100.0000%
                            225,449      259,367      269,878      275,154      279,922      286,416      289,786      290,433          16
 MEDICAL                   60.3618%     82.0475%     87.9938%     90.5996%     93.6990%     97.5077%     99.5248%    100.0000%
                             48,193       57,841       62,033       63,870       66,055       68,740       70,162       70,497          24
 OUTPATIENT HOSPITAL       43.8713%     61.3338%     71.3896%     79.1623%     86.1915%     94.6671%     98.5535%    100.0000%
                              7,552       10,558       12,289       13,627       14,837       16,296       16,965       17,214          48
 MEDICARE CROSSOVER         4.3216%     40.5626%     62.2904%     74.7909%     85.9269%     94.4900%     98.8876%    100.0000%
                              1,080       10,137       15,567       18,691       21,474       23,614       24,713       24,991          39
                    TOTAL  70.8268%     84.1292%     89.3363%     92.1283%     94.8137%     97.9839%     99.6192%    100.0000%
                            303,174      360,115      382,404      394,355      405,850      419,420      426,420      428,050

CLEAN CLAIMS (UNIQUE LINE ITEM)
 INPATIENT HOSPITAL        77.6124%     84.9587%     87.1874%     89.2855%     92.7084%     97.5529%     99.7609%    100.0000%
                             36,030       39,445       40,475       41,449       43,038       45,287       46,312       46,423          22
 DRUG                      78.6414%     90.3197%     93.8026%     95.5057%     96.9846%     98.9462%     99.8997%    100.0000%
                            218,653      251,123      260,807      265,542      269,654      275,108      277,759      278,038          14
 MEDICAL                   64.6945%     79.4491%     86.1810%     89.6035%     93.4275%     97.8249%     99.8481%    100.0000%
                             77,929       95,702      103,811     '108,030      112,540      117,837      120,274      120,457          24
 OUTPATIENT HOSPITAL       45.7674%     64.7931%     74.4896%     81.1195%     88.2771%     96.2415%     99.6100%    100.0000%
                             11,970       16,946       19,482       21,216       23,088       25,171       26,052       26,154          42
 MEDICARE CROSSOVER         5.4539%     39.6716%     61.6494%     74.3745%     86.1162%     94.8820%     98.9551%    100.0000%
                              2,923       21,262       33,041       39,861       46,154       50,852       53,035       53,595          58
                    TOTAL  66.2334%     80.9043%     87.2203%     90.7429%     94.2453%     98.0155%     99.7646%    100.0000%
                            347,505      424,478      457,616      476,098      494,474      514,255      523,432      524,667

ALL CLAIMS (UNIQUE LINE-ITEM)
 INPATIENT HOSPITAL        75.2376%     82.7012%     85.2649%     87.6208%     91.2428%     96.6269%     99.3434%    100.0000%
                             38,387       42,195       43,503       44,705       46,553       49,300       50,686       51,021          27
 DRUG                      77.6251%     89.3036%     92.9226%     94.7392%     96.3809%     98.6169%     99.7772%    100.0000%
                            225,449      259,367      269,878      275,154      279,922      286,416      289,786      290,433          16
 MEDICAL                   62.8559%     77.3878%     84.1815%     87.7900%     91.8297%     96.9070%     99.5211%    100.0000%
                             85,841      105,687      114,965      119,893      125,410      132,344      135,914      136,568          29
 OUTPATIENT HOSPITAL       44.1410%     62.8134%     72.4329%     79.0249%     86.0649%     94.4721%     98.4319%    100.0000%
                             13,399       19,067       21,987       23,906       26,125       28,677       29,879       30,355          39
 MEDICARE CROSSOVER        64.8303%     79.7743%     86.1839%     89.9200%     93.5943%     97.5480%     99.5133%    100.0000%
                            281,182      345,997      373,797      390,001      405,937      423,085      431,609      433,720          26
                    TOTAL  68.3855%     81.9781%     87.4783%     90.6213%     93.0276%     97.6356%     99.5517%    100.0000%
                            644,258      772,313      824,130      853,741      883,947      919,822      937,874      942,097
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WM106-08R                           INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                                        DATE 06/20/80
                                        BILL & CLAIM PROCESSING THRUPUT ANALYSIS                                          PAGE    5
TYPE OF BILL
 BILLING DATE-RECEIPT DATE 15   DAYS   30   DAYS   45   DAYS   60   DAYS   90   DAYS   180  DAYS   365  DAYS   365  PLUS  AVG. DAYS

CLEAN BILLS (UNIQUE ICN)
 INPATIENT HOSPITAL         95.7856%    98.1222%    98.7910%    99.0868%    99.6141%    99.9057%    99.9914%   100.0000%
                              22,342      22,887      23,043      23,112      23,235      23,303      23,323      23,325          6
 DRUG (SAME AS CLEAN CLAIMS 81.5117%    93.7146%    96.6259%    98.0404%    98.8139%    99.3940%    99.5823%   100.0000%
                             223,823     257,331     265,325     269,209     271,333     272,926     273,443     274,590         80
 MEDICAL                    65.4885%    91.2009%    95.8698%    97.8854%    98.8608%    99.6965%    99.9821%   100.0000%
                              40,354      56,198      59,075      60,317      60,918      61,433      61,609      61,620         17
 OUTPATIENT HOSPITAL        92.0703%    96.8470%    97.9249%    98.4100%    98.9153%    99.4610%    99.8114%   100.0000%
                              13,666      14,375      14,535      14,607      14,682      14,763      14,815      14,843         23
 MEDICARE CROSSOVER        100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                              23,323      23,323      23,323      23,323      23,323      23,323      23,323      23,323          1
                      TOTAL 81.3445%    94.0692%    96.8821%    98.2064%    98.9414%    99.5089%    99.7013%   100.0000%
                             323,508     374,114     385,301     390,560     393,491     395,748     396,513     397,701

ALL BILLS (UNIQUE ICN)
 INPATIENT HOSPITAL         95.1018%    97.6616%    98.3901%    98.7765%    99.4164%    99.8269%    99.9678%   100.0000%
                              23,629      24,265      24,446      24,542      24,701      24,803      24,838      24,846          7
 DRUG (SAME AS ALL CLAIMS)  81.0285%    93.2779%    96.2870%    97.7537%    98.6222%    99.3177%    99.5489%   100.0000%
                             232,414     267,549     276,180     280,387     282,878     284,873     285,536     286,830         83
 MEDICAL                    64.9435%    90.5343%    95.2840%    97.3551%    98.4794%    99.5112%    99.9105%   100.0000%
                              44,246      61,681      64,917      66,328      67,094      67,797      68,069      68,130         18
 OUTPATIENT HOSPITAL        91.3536%    96.2554%    97.4648%    97.9940%    98.6161%    99.3139%    99.7732%   100.0000%
                              15,711      16,554      16,762      16,853      16,960      17,080      17,159      17,198         23
 MEDICARE CROSSOVER        100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                              24,991      24,991      24,991      24,991      24,991      24,991      24,991      24,991          1
                      TOTAL 80.8045%    93.6125%    96.5168%    97.8924%    98.7272%    99.4192%    99.6678%   100.0000%
                             340,991     395,040     407,296     413,101     416,624     419,544     420,593     421,995

CLEAN CLAIMS (UNIQUE LINE ITEM)
 INPATIENT HOSPITAL         92.5775%    96.0813%    97.3111%    97.8710%    99.1138%    99.7644%    99.9697%   100.0000%
                              42,831      44,452      45,021      45,280      45,855      46,156      46,251      46,265          8
 DRUG                       81.5117%    93.7146%    96.6259%    98.0404%    98.8139%    99.3940%    99.5823%   100.0000%
                             223,823     257,331     265,325     269,209     271,333     272,926     273,443     274,590         80
 MEDICAL                    65.2323%    90.4535%    95.4142%    97.6068%    98.7820%    99.7190%    99.9838%   100.0000%
                              76,374     105,903     111,711     114,278     115,654     116,751     117,061     117,080         17
 OUTPATIENT HOSPITAL        92.1143%    96.4991%    97.6661%    98.2170%    98.7412%    99.4337%    99.8240%   100.0000%
                              24,075      25,221      25,526      25,670      25,807      25,988      26,090      26,136         23
 MEDICARE CROSSOVER        100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                              53,595      53,595      53,595      53,595      53,595      53,595      53,595      53,595          1
                      TOTAL 81.2682%    93.9799%    96.8149%    98.1390%    98.9526%    99.5654%    99.7632%   100.0000%
                             420,698     486,502     501,178     508,032     512,244     515,416     516,440     517,666

ALL CLAIMS (UNIQUE LINE-ITEM)
 INPATIENT HOSPITAL         91.1213%    94.9658%    96.3443%    97.0385%    98.6018%    99.6028%    99.9312%   100.0000%
                              46,337      48,292      48,993      49,346      50,141      50,650      50,817      50,852          9
 DRUG                       81.0285%    93.2779%    96.2870%    97.7537%    98.6222%    99.3177%    99.5489%   100.0000%
                             232,414     267,549     276,180     280,387     282,878     284,873     285,536     286,830         83
 MEDICAL                    64.5056%    89.6602%    94.7739%    97.0159%    98.3877%    99.5340%    99.9216%   100.0000%
                              85,537     118,893     125,674     128,647     130,466     131,986     132,500     132,604         18
 OUTPATIENT HOSPITAL        91.2034%    95.7006%    97.0557%    97.6822%    98.3647%    99.2911%    99.7857%   100.0000%
                              27,662      29,026      29,437      29,627      29,834      30,115      30,265      30,330         23
 MEDICARE CROSSOVER         85.6721%    94.6165%    96.8827%    97.9875%    98.8000%    99.4478%    99.6758%   100.0000%
                             368,324     406,778     416,521     421,271     424,764     427,549     428,529     429,923         58
                      TOTAL 81.7025%    93.5520%    96.3748%    97.7152%    98.6614%    99.4233%    99.6892%   100.0000%
                             760,274     870,538     896,805     909,278     918,083     925,173     927,647     930,539
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WI106-08R                          INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                                  DATE 06/10/80
                                      BILL & CLAIM PROCESSING THRUPUT ANALYSIS                                     PAGE    6
TYPE OF BILL
 RECEIPT DATE-ADJ DATE       15   DAYS   30   DAYS   45   DAYS   60   DAYS   90   DAYS   180  DAYS   365  DAYS   365  PLUS   AVG. DAYS

CLEAN BILLS (UNIQUE ICN)
 INPATIENT HOSPITAL          90.7447%     99.5255%     99.9573%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                               21,227       23,281       23,382       23,392       23,392       23,392       23,392       23,392
 DRUG (SAME AS CLEAN CLAIMS  88.9270%     99.2979%     99.9929%     99.9961%     99.9961%    100.0000%    100.0000%    100.0000%
                              250,928      280,192      282,153      282,162      282,162      282,173      282,173      282,173
 MEDICAL                     64.4189%     95.1488%     99.4404%     99.9138%     99.9875%    100.0000%    100.0000%    100.0000%
                               41,098       60,703       63,441       63,743       63,790       63,798       63,798       63,798
 OUTPATIENT HOSPITAL         79.3224%     99.5514%     99.9866%     99.9866%     99.9866%     99.9866%    100.0000%    100.0000%
                               11,846       14,867       14,932       14,932       14,932       14,932       14,934       14,934
 MEDICARE CROSSOVER          98.4179%     99.7899%     99.9914%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                               22,954       23,274       23,321       23,323       23,323       23,323       23,323       23,323
                      TOTAL  85.3066%     98.6990%     99.9041%     99.9833%     99.9948%     99.9995%    100.0000%    100.0000%
                              348,053      402,317      407,229      407,552      407,599      407,618      407,620      407,620

ALL BILLS (UNIQUE ICN)
 INPATIENT HOSPITAL          89.4802%     99.3859%     99.9518%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                               22,294       24,762       24,903       24,915       24,915       24,915       24,915       24,915
 DRUG (SAME AS ALL CLAIMS)   87.0964%     99.1951%     99.9925%     99.9963%     99.9963%    100.0000%    100.0000%    100.0000%
                              256,776      292,445      294,796      294,807      294,807      294,818      294,818      294,818
 MEDICAL                     60.6430%     94.7019%     99.3754%     99.9023%     99.9858%    100.0000%    100.0000%    100.0000%
                               42,820       66,869       70,169       70,541       70,600       70,610       70,610       70,610
 OUTPATIENT HOSPITAL         73.1323%     99.3586%     99.9769%     99.9769%     99.9769%     99.9769%    100.0000%    100.0000%
                               12,657       17,196       17,303       17,303       17,303       17,303       17,307       17,307
 MEDICARE CROSSOVER          98.1994%     99.7799%     99.9920%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                               24,541       24,936       24,989       24,991       24,991       24,991       24,991       24,991
                      TOTAL  82.9991%     98.5131%     99.8888%     99.9806%     99.9942%     99.9991%    100.0000%    100.0000%
                              359,088      426,208      432,160      432,557      432,616      432,637      432,641      432,641

CLEAN CLAIMS (UNIQUE LINE ITEM)
 INPATIENT HOSPITAL          83.2626%     99.3861%     99.9332%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                               38,653       46,138       46,392       46,423       46,423       46,423       46,423       46,423
 DRUG                        88.9270%     99.2979%     99.9929%     99.9961%     99.9961%    100.0000%    100.0000%    100.0000%
                              250,928      280,192      282,153      282,162      282,162      282,173      282,173      282,173
 MEDICAL                     55.0170%     92.7393%     99.0869%     99.8043%     99.9876%    100.0000%    100.0000%    100.0000%
                               66,341      111,826      119,480      120,345      120,566      120,581      120,581      120,581
 OUTPATIENT HOSPITAL         77.7072%     99.4751%     99.9924%     99.9924%     99.9924%     99.9924%    100.0000%    100.0000%
                               20,430       26,153       26,289       26,289       26,289       26,289       26,291       26,291
 MEDICARE CROSSOVER          97.6509%     99.6343%     99.9869%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                               52,336       53,399       53,588       53,595       53,595       53,595       53,595       53,595
                      TOTAL  81.0278%     97.8538%     99.7806%     99.9529%     99.9947%     99.9996%    100.0000%    100.0000%
                              428,688      517,708      527,902      528,814      529,035      529,061      529,063      529,063

ALL CLAIMS (UNIQUE LINE-ITEM)
 INPATIENT HOSPITAL          81.2959%     99.1846%     99.9255%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                               41,478       50,605       50,983       51,021       51,021       51,021       51,021       51,021
 DRUG                        87.0964%     99.1951%     99.9925%     99.9963%     99.9963%    100.0000%    100.0000%    100.0000%
                              256,776      292,445      294,796      294,807      294,807      294,818      294,818      294,818
 MEDICAL                     51.2396%     91.9471%     98.8891%     99.7828%     99.9832%    100.0000%    100.0000%    100.0000%
                               70,062      125,723      135,215      136,437      136,711      136,734      136,734      136,734
 OUTPATIENT HOSPITAL         71.5339%     99.2824%     99.9836%     99.9836%     99.9836%     99.9836%    100.0000%    100.0000%
                               21,830       30,298       30,512       30,512       30,512       30,512       30,517       30,517
 MEDICARE CROSSOVER          86.8379%     99.2662%     99.9833%     99.9963%     99.9963%     99.9989%    100.0000%    100.0000%
                              380,582      435,051      438,194      438,251      438,251      438,262      438,267      438,267
                      TOTAL  81.0135%     98.1884%     99.8258%     99.9654%     99.9942%     99.9989%    100.0000%    100.0000%
                              770,728      934,122      949,700      951,028      951,302      951,347      951,357      951,357
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MR06-08R                             INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                               DATE 06/10/80
                                       BILL & CLAIM PROCESSING THRUPUT ANALYSIS                                  PAGE    7
TYPE OF BILL
 RECEIPT DATE-CHECK DATE   15    DAYS   30    DAYS   45    DAYS   60    DAYS   90    DAYS   180  DAYS   365  DAYS   365  PLUS   AVG. DAYS

CLEAN BILLS (UNIQUE ICN)
 INPATIENT HOSPITAL          71.8622%    98.9569%    99.8504%    99.9829%   100.0000%   100.0000%   100.0000%   100.0000%
                               16,810      23,148      23,357      23,388      23,392      23,392      23,392      23,392          13
 DRUG (SAME AS CLEAN CLAIMS  37.2963%    94.1242%    99.9511%    99.9957%    99.9961%   100.0000%   100.0000%   100.0000%
                              105,240     265,593     282,035     282,161     282,162     282,173     282,173     282,173          17
 MEDICAL                     11.9377%    90.1000%    98.5250%    99.8213%    99.9875%   100.0000%   100.0000%   100.0000%
                                7,616      57,482      62,857      63,684      63,790      63,798      63,798      63,798          22
 OUTPATIENT HOSPITAL         44.5494%    98.2724%    99.9464%    99.9866%    99.9866%    99.9866%   100.0000%   100.0000%
                                6,653      14,676      14,926      14,932      14,932      14,932      14,934      14,934          17
 MEDICARE CROSSOVER          91.5363%    99.3703%    99.9443%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                               21,349      23,178      23,310      23,323      23,323      23,323      23,323      23,323          14
                     TOTAL   38.6801%    94.2243%    99.7216%    99.9676%    99.9948%    99.9995%   100.0000%   100.0000%
                              157,660     384,077     406,485     407,488     407,599     407,618     407,620     407,620

ALL BILLS (UNIQUE ICN)
 INPATIENT HOSPITAL          68.9504%    98.5671%    99.7752%    99.9799%   100.0000%   100.0000%   100.0000%   100.0000%
                               17,179      24,558      24,859      24,910      24,915      24,915      24,915      24,915          13
 DRUG (SAME AS ALL CLAIMS)   36.4544%    92.9818%    99.9461%    99.9959%    99.9963%   100.0000%   100.0000%   100.0000%
                              107,474     274,127     294,659     294,806     294,807     294,818     294,818     294,818          18
 MEDICAL                     11.3001%    88.2240%    98.3458%    99.8074%    99.9858%   100.0000%   100.0000%   100.0000%
                                7,979      62,295      69,442      70,474      70,600      70,610      70,610      70,610          22
 OUTPATIENT HOSPITAL         40.1225%    97.5443%    99.8787%    99.9769%    99.9769%    99.9769%   100.0000%   100.0000%
                                6,944      16,882      17,286      17,303      17,303      17,303      17,307      17,307          18
 MEDICARE CROSSOVER          90.0564%    99.3198%    99.9400%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                               22,506      24,821      24,976      24,991      24,991      24,991      24,991      24,991          14
                     TOTAL   37.4634%    93.0756%    99.6720%    99.9637%    99.9942%    99.9991%   100.0000%   100.0000%
                              162,082     402,683     431,222     432,484     432,616     432,637     432,641     432,641

CLEAN CLAIMS (UNIQUE LINE ITEM)
 INPATIENT HOSPITAL          57.0321%    98.2681%    99.8191%    99.9849%   100.0000%   100.0000%   100.0000%   100.0000%
                               26,476      45,619      46,339      46,416      46,423      46,423      46,423      46,423          15
 DRUG                        37.2963%    94.1242%    99.9511%    99.9957%    99.9961%   100.0000%   100.0000%   100.0000%
                              105,240     265,593     282,035     282,161     282,162     282,173     282,173     282,173          17
 MEDICAL                      9.6334%    86.4680%    97.5883%    99.6110%    99.9876%   100.0000%   100.0000%   100.0000%
                               11,616     104,264     117,673     120,112     120,566     120,581     120,581     120,581          23
 OUTPATIENT HOSPITAL         43.3456%    97.9575%    99.9620%    99.9924%    99.9924%    99.9924%   100.0000%   100.0000%
                               11,396      25,754      26,281      26,289      26,289      26,289      26,291      26,291          17
 MEDICARE CROSSOVER          87.4615%    98.9570%    99.8414%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                               46,875      53,036      53,510      53,595      53,595      53,595      53,595      53,595          15
                     TOTAL   38.1057%    93.4229%    99.3904%    99.9074%    99.9947%    99.9996%   100.0000%   100.0000%
                              201,603     494,266     525,838     528,573     529,035     529,061     529,063     529,063

ALL CLAIMS (UNIQUE LINE-ITEM)
 INPATIENT HOSPITAL          53.7445%    97.7754%    99.7315%    99.9784%   100.0000%   100.0000%   100.0000%   100.0000%
                               27,421      49,886      50,884      51,010      51,021      51,021      51,021      51,021          16
 DRUG                        36.4544%    92.9818%    99.9461%    99.9959%    99.9963%   100.0000%   100.0000%   100.0000%
                              107,474     274,127     294,659     294,806     294,807     294,818     294,818     294,818          18
 MEDICAL                      9.0350%    84.1371%    97.2640%    99.5853%    99.9832%   100.0000%   100.0000%   100.0000%
                               12,355     115,044     132,993     136,167     136,711     136,734     136,734     136,734          24
 OUTPATIENT HOSPITAL         39.1814%    97.1131%    99.8558%    99.9836%    99.9836%    99.9836%   100.0000%   100.0000%
                               11,957      29,636      30,473      30,512      30,512      30,512      30,517      30,517          18
 MEDICARE CROSSOVER          45.9323%    94.6804%    99.9019%    99.9936%    99.9963%    99.9989%   100.0000%   100.0000%
                              201,306     414,953     437,837     438,239     438,251     438,262     438,267     438,267          17
                     TOTAL   37.8946%    92.8327%    99.5258%    99.9345%    99.9942%    99.9989%   100.0000%   100.0000%
                              360,513     883,646     946,846     950,734     951,302     951,347     951,357     951,357
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WH106-0CR                        INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                                  DATE 06/10/80
                            ALL CLAIM (UNIQUE LINE ITEM) PROCESSING THRUPUT ANALYSIS                             PAGE   8
                                        MEDICARE CROSSOVERS NOT INCLUDED

INSTITUTIONAL PROVIDERS    15   DAYS   30   DAYS   45   DAYS   60   DAYS   90   DAYS   100  DAYS   365  DAYS   365  PLUS   AVG. DAYS

HOME HEALTH AGENCIES
 LAST SVC DATE - CHECK DATE   .0000%      .1626%     7.5610%    36.0163%    69.7561%    89.0244%    99.5935%   100.0000%
                                   0           2          93         443         850       1,095       1,225       1,230         92
 LAST SVC DATE - ADJ DATE     .0813%     1.4634%    21.4634%    46.1789%    73.8211%    90.3252%    99.5935%   100.0000%
                                   1          18         264         568         908       1,111       1,225       1,230         85
 LAST SVC DATE - RCPT DATE   2.8455%    14.6341%    48.7805%    65.9350%    80.2439%    92.4390%    99.8374%   100.0000%
                                  35         180         600         811         987       1,137       1,228       1,230         68
 LAST SVC DATE - BILL DATE  33.1971%    63.7776%    78.0049%    82.9926%    90.8422%    97.0564%    99.8365%   100.0000%
                                 406         780         954       1,015       1,111       1,187       1,221       1,223         37
 BILLING DATE - RCPT DATE   33.4694%    76.6531%    88.4898%    92.0000%    93.0612%    97.1429%   100.0000%   100.0000%
                                 410         939       1,084       1,127       1,140       1,190       1,225       1,225         32
 RECEIPT DATE - ADJ DATE    61.7886%    88.6992%    98.2114%    99.6748%   100.0000%   100.0000%   100.0000%   100.0000%
                                 760       1,091       1,208       1,226       1,230       1,230       1,230       1,230         17
 RECEIPT DATE - CHECK DATE   1.3008%    80.0813%    95.8537%    98.5366%   100.0000%   100.0000%   100.0000%   100.0000%
                                  16         985       1,179       1,212       1,230       1,230       1,230       1,230         24

HOSPITALS, GENERAL
 LAST SVC DATE - CHECK DATE   .0611%    22.7056%    50.1144%    63.4155%    76.7147%    92.0035%    98.2607%   100.0000%
                                  31      11,514      25,413      32,158      38,902      46,655      49,828      50,710         76
 LAST SVC DATE - ADJ DATE    3.8099%    36.6713%    57.2077%    67.6190%    78.5447%    92.5833%    98.3139%   100.0000%
                               1,932      18,596      29,010      34,290      39,830      46,949      49,855      50,710         69
 LAST SVC DATE - RCPT DATE  31.6742%    55.5255%    65.8726%    73.0034%    81.5303%    93.4175%    98.5072%   100.0000%
                              16,062      28,157      33,404      37,020      41,344      47,372      49,953      50,710         57
 LAST SVC DATE - BILL DATE  47.9079%    64.5320%    72.1843%    77.9710%    85.2197%    94.5002%    98.7042%   100.0000%
                              24,216      32,619      36,487      39,412      43,076      47,767      49,892      50,547         48
 BILLING DATE - RCPT DATE   87.6200%    93.3202%    95.1302%    95.9766%    97.7827%    99.2092%    99.8172%   100.0000%
                              44,100      46,969      47,880      48,306      49,215      49,933      50,239      50,331         20
 RECEIPT DATE - ADJ DATE    68.8424%    99.2408%    99.9665%    99.9901%    99.9901%    99.9901%   100.0000%   100.0000%
                              34,910      50,325      50,693      50,705      50,705      50,705      50,710      50,710         12
 RECEIPT DATE - CHECK DATE  32.8929%    96.9868%    99.8146%    99.9901%    99.9901%    99.9901%   100.0000%   100.0000%
                              16,680      49,182      50,616      50,705      50,705      50,705      50,710      50,710         19

HOSPITALS, GENERAL-WITH NURSING HOME
 LAST SVC DATE - CHECK DATE   .0000%    31.1221%    53.6268%    60.4464%    71.1097%    91.3825%    97.8301%   100.0000%
                                   0         502         865         975       1,147       1,474       1,578       1,613         81
 LAST SVC DATE - ADJ DATE   11.6553%    43.7694%    57.9045%    62.9882%    72.8456%    91.3825%    97.8301%   100.0000%
                                 188         706         934       1,016       1,175       1,474       1,578       1,613         74
 LAST SVC DATE - RCPT DATE  46.0632%    55.1767%    62.3683%    67.2660%    76.8754%    91.8785%    97.8301%   100.0000%
                                 743         890       1,006       1,085       1,240       1,482       1,578       1,613         62
 LAST SVC DATE - BILL DATE  57.5945%    62.7402%    69.0019%    73.0316%    81.2771%    92.3125%    98.2021%   100.0000%
                                 929       1,012       1,113       1,178       1,311       1,489       1,584       1,613         52
 BILLING DATE - RCPT DATE   91.0448%    92.9726%    94.2164%    96.3308%    97.0771%    99.5647%    99.6891%   100.0000%
                               1,464       1,495       1,515       1,549       1,561       1,601       1,603       1,608         10
 RECEIPT DATE - ADJ DATE    60.0124%    98.8221%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                 968       1,594       1,613       1,613       1,613       1,613       1,613       1,613         13
 RECEIPT DATE - CHECK DATE  33.6020%    97.3962%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                 542       1,571       1,613       1,613       1,613       1,613       1,613       1,613         20
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WI06-00R

INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM
ALL CLAIM (UNIQUE LINE ITEM) PROCESSING THRUPUT ANALYSIS
MEDICARE CROSSOVERS NOT INCLUDED

INSTITUTIONAL PROVIDERS	15 DAYS	30 DAYS	45 DAYS	60 DAYS	90 DAYS	100 DAYS	365 DAYS	365 PLUS	AVG. DAYS
HOSPITALS, MENTAL (PSYCH)									
LAST SVC DATE - CHECK DATE	.0000% 0	.9346% 1	81.3084% 87	86.9159% 93	89.7196% 96	96.2617% 103	100.0000% 107	100.0000% 107	51
LAST SVC DATE - ADJ DATE	.0000% 0	44.8598% 48	85.0467% 91	88.7850% 95	89.7196% 96	96.2617% 103	100.0000% 107	100.0000% 107	46
LAST SVC DATE - RCPT DATE	.9346% 1	85.9813% 92	88.7850% 95	89.7196% 96	89.7196% 96	96.2617% 103	100.0000% 107	100.0000% 107	32
LAST SVC DATE - BILL DATE	80.3738% 86	86.9159% 93	91.5888% 98	91.5888% 98	91.5888% 98	96.2617% 103	100.0000% 107	100.0000% 107	25
BILLING DATE - RCPT DATE	96.2617% 103	98.1308% 105	98.1308% 105	98.1308% 105	100.0000% 107	100.0000% 107	100.0000% 107	100.0000% 107	6
RECEIPT DATE - ADJ DATE	86.9159% 93	100.0000% 107	100.0000% 107	100.0000% 107	100.0000% 107	100.0000% 107	100.0000% 107	100.0000% 107	14
RECEIPT DATE - CHECK DATE	1.8692% 2	97.1963% 104	100.0000% 107	100.0000% 107	100.0000% 107	100.0000% 107	100.0000% 107	100.0000% 107	20
NURSING HOMES, SKILLED									
LAST SVC DATE - CHECK DATE	28.8222% 2,151	71.5128% 5,337	82.9961% 6,194	86.9891% 6,492	91.1028% 6,799	96.4224% 7,196	99.0218% 7,390	100.0000% 7,463	40
LAST SVC DATE - ADJ DATE	66.0994% 4,933	77.4219% 5,778	86.3996% 6,448	88.2085% 6,583	91.7325% 6,846	96.4357% 7,197	99.0620% 7,393	100.0000% 7,463	33
LAST SVC DATE - RCPT DATE	76.5778% 5,715	84.3227% 6,293	87.6457% 6,541	88.9569% 6,639	92.6839% 6,917	96.8109% 7,225	99.0888% 7,395	100.0000% 7,463	25
LAST SVC DATE - BILL DATE	81.7500% 6,101	86.9087% 6,486	89.1867% 6,656	91.3306% 6,816	94.1310% 7,025	97.2397% 7,257	99.2764% 7,409	100.0000% 7,463	19
BILLING DATE - RCPT DATE	96.4578% 7,189	98.1081% 7,312	98.9266% 7,373	99.3560% 7,405	99.6377% 7,426	99.8390% 7,441	99.9732% 7,451	100.0000% 7,453	6
RECEIPT DATE - ADJ DATE	88.3961% 6,597	97.8963% 7,306	99.7722% 7,446	100.0000% 7,463	100.0000% 7,463	100.0000% 7,463	100.0000% 7,463	100.0000% 7,463	9
RECEIPT DATE - CHECK DATE	58.2742% 4,349	95.8730% 7,155	99.3032% 7,411	99.9196% 7,457	100.0000% 7,463	100.0000% 7,463	100.0000% 7,463	100.0000% 7,463	15
NURSING HOMES, INTERMEDIATE CARE									
LAST SVC DATE - CHECK DATE	44.8540% 9,941	85.7149% 18,997	91.4407% 20,266	93.5659% 20,737	95.9527% 21,266	98.1049% 21,743	99.4901% 22,050	100.0000% 22,163	28
LAST SVC DATE - ADJ DATE	75.6125% 16,758	88.0070% 19,505	92.9116% 20,592	94.0667% 20,848	96.1873% 21,318	98.1185% 21,746	99.5037% 22,053	100.0000% 22,163	22
LAST SVC DATE - RCPT DATE	87.2355% 19,334	91.7610% 20,337	93.7689% 20,782	94.7164% 20,992	96.4445% 21,375	98.2945% 21,785	99.5262% 22,058	100.0000% 22,163	16
LAST SVC DATE - BILL DATE	91.6528% 20,313	93.7012% 20,767	94.8969% 21,032	95.6459% 21,198	96.8235% 21,459	98.4298% 21,815	99.5578% 22,065	100.0000% 22,163	12
BILLING DATE - RCPT DATE	96.5052% 21,318	98.6510% 21,792	99.2123% 21,916	99.4613% 21,971	99.7827% 22,042	99.9366% 22,076	99.9864% 22,087	100.0000% 22,090	5
RECEIPT DATE - ADJ DATE	92.6544% 20,535	99.4315% 22,037	99.9549% 22,153	100.0000% 22,163	100.0000% 22,163	100.0000% 22,163	100.0000% 22,163	100.0000% 22,163	6
RECEIPT DATE - CHECK DATE	75.8968% 16,821	98.6915% 21,873	99.7383% 22,105	99.9774% 22,158	100.0000% 22,163	100.0000% 22,163	100.0000% 22,163	100.0000% 22,163	12

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WM106-08R                         INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                               DATE 06/10/80
                               ALL CLAIM (UNIQUE LINE ITEM) PROCESSING THRUPUT ANALYSIS                        PAGE  10
                                          MEDICARE CROSSOVERS NOT INCLUDED

INSTITUTIONAL PROVIDERS     15   DAYS    30   DAYS    45   DAYS    60   DAYS    90   DAYS   100  DAYS   365  DAYS   365  PLUS    AVG. DAYS

NURSING HOMES, ICF-MR
 LAST SVC DATE - CHECK DATE  2.5784%    58.5440%    85.6421%    91.1021%    92.5683%    96.2083%    99.5956%   100.0000%
                                  51       1,158       1,694       1,802       1,831       1,903       1,970       1,978          43
 LAST SVC DATE - ADJ DATE   15.8241%    64.7624%    90.5460%    91.2538%    92.5683%    96.2083%    99.5956%   100.0000%
                                 313       1,281       1,791       1,805       1,831       1,903       1,970       1,978          37
 LAST SVC DATE - RCPT DATE  23.6097%    86.2993%    91.1021%    92.1132%    93.1749%    97.5733%    99.7978%   100.0000%
                                 467       1,707       1,802       1,822       1,843       1,930       1,974       1,978          32
 LAST SVC DATE - BILL DATE  65.4702%    91.0010%    91.3549%    92.2649%    93.2255%    97.5733%    99.7978%   100.0000%
                               1,295       1,800       1,807       1,825       1,844       1,930       1,974       1,978          26
 BILLING DATE - RCPT DATE   97.3178%    99.1397%    99.8988%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                               1,923       1,959       1,974       1,976       1,976       1,976       1,976       1,976           6
 RECEIPT DATE - ADJ DATE    93.5794%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                               1,851       1,978       1,978       1,978       1,978       1,978       1,978       1,978           6
 RECEIPT DATE - CHECK DATE  69.1608%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                               1,368       1,978       1,978       1,978       1,978       1,978       1,978       1,978          12

NURSING HOMES, SKILLED-PEDIATRIC
 LAST SVC DATE - CHECK DATE   .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%
                                   0           0           0           0           0           0           0           0
 LAST SVC DATE - ADJ DATE     .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%
                                   0           0           0           0           0           0           0           0
 LAST SVC DATE - RCPT DATE    .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%
                                   0           0           0           0           0           0           0           0
 LAST SVC DATE - BILL DATE    .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%
                                   0           0           0           0           0           0           0           0
 BILLING DATE - RCPT DATE     .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%
                                   0           0           0           0           0           0           0           0
 RECEIPT DATE - ADJ DATE      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%
                                   0           0           0           0           0           0           0           0
 RECEIPT DATE - CHECK DATE    .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%
                                   0           0           0           0           0           0           0           0

NURSING HOMES, INTERMEDIATE-INCLUSIVE
 LAST SVC DATE - CHECK DATE   .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%
                                   0           0           0           0           0           0           0           0
 LAST SVC DATE - ADJ DATE     .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%
                                   0           0           0           0           0           0           0           0
 LAST SVC DATE - RCPT DATE    .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%
                                   0           0           0           0           0           0           0           0
 LAST SVC DATE - BILL DATE    .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%
                                   0           0           0           0           0           0           0           0
 BILLING DATE - RCPT DATE     .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%
                                   0           0           0           0           0           0           0           0
 RECEIPT DATE - ADJ DATE      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%
                                   0           0           0           0           0           0           0           0
 RECEIPT DATE - CHECK DATE    .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%
                                   0           0           0           0           0           0           0           0
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MR106-00R                          INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                             DATE 06/10/80
                               ALL CLAIM (UNIQUE LINE ITEM) PROCESSING THRUPUT ANALYSIS                        PAGE  11
                                          MEDICARE CROSSOVERS NOT INCLUDED

INSTITUTIONAL PROVIDERS    15   DAYS   30   DAYS   45   DAYS   60   DAYS   90   DAYS   100  DAYS   365  DAYS   365  PLUS   AVG. DAYS

RESIDENTIAL CARE FACILITIES
 LAST SVC DATE - CHECK DATE  .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%       0000%
                                  0           0           0           0           0           0           0           0
 LAST SVC DATE - ADJ DATE    .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%       0000%
                                  0           0           0           0           0           0           0           0
 LAST SVC DATE - RCPT DATE   .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%       0000%
                                  0           0           0           0           0           0           0           0
 LAST SVC DATE - BILL DATE   .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%       0000%
                                  0           0           0           0           0           0           0           0
 BILLING DATE - RCPT DATE    .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%       0000%
                                  0           0           0           0           0           0           0           0
 RECEIPT DATE - ADJ DATE     .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%       0000%
                                  0           0           0           0           0           0           0           0
 RECEIPT DATE - CHECK DATE   .0000%      .0000%      .0000%      .0000%      .0000%      .0000%      .0000%       0000%
                                  0           0           0           0           0           0           0           0
```

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MR106-00R                           INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                              DATE 06/10/80
                                 ALL CLAIM (UNIQUE LINE ITEM) PROCESSING THRUPUT ANALYSIS                          PAGE  12
                                             MEDICARE CROSSOVERS NOT INCLUDED

SERVICES PROVIDERS          15   DAYS    30   DAYS    45   DAYS    60   DAYS    90   DAYS   100  DAYS   365  DAYS   365  PLUS   AVG. DAYS

AUDIOLOGISTS
 LAST SVC DATE - CHECK DATE   .0000%       .5556%    14.4444%    31.0519%    70.5185%    97.5926%    99.8148%   100.0000%
                                   0            3          78         172         424         527         539         540          76
 LAST SVC DATE - ADJ DATE     .0000%      3.7037%    20.9259%    44.0741%    82.2222%    97.7778%    99.8148%   100.0000%
                                   0           20         113         238         444         528         539         540          70
 LAST SVC DATE - RCPT DATE   8.5185%     43.1481%    59.2593%    85.3704%    93.3333%    99.0741%    99.8148%   100.0000%
                                  46          233         320         461         504         535         539         540          43
 LAST SVC DATE - BILL DATE  50.2783%     68.6456%    91.2801%    93.1354%    96.1039%    99.4434%   100.0000%   100.0000%
                                 271          370         492         502         518         536         539         539          24
 BILLING DATE - RCPT DATE   44.6097%     86.4312%    94.6097%    95.3532%    99.8141%   100.0000%   100.0000%   100.0000%
                                 240          465         509         513         537         538         538         538          20
 RECEIPT DATE - ADJ DATE    40.1852%     69.4444%    82.2222%    90.5556%    97.4074%   100.0000%   100.0000%   100.0000%
                                 217          375         444         489         526         540         540         540          27
 RECEIPT DATE - CHECK DATE   5.7407%     63.1481%    76.8519%    88.7037%    97.4074%   100.0000%   100.0000%   100.0000%
                                  31          341         415         479         526         540         540         540          33

CHIROPRACTORS
 LAST SVC DATE - CHECK DATE   .0000%       .5882%    10.5882%    27.6471%    52.9412%    83.5294%    97.6471%   100.0000%
                                   0            1          18          47          90         142         166         170          09
 LAST SVC DATE - ADJ DATE     .0000%      1.1765%    22.3529%    34.1176%    55.8824%    85.2941%    97.6471%   100.0000%
                                   0            2          38          58          95         145         166         170          02
 LAST SVC DATE - RCPT DATE   4.1176%     25.8824%    41.1765%    51.7647%    71.1765%    88.8235%    97.6471%   100.0000%
                                   7           44          70          88         121         151         166         170          60
 LAST SVC DATE - BILL DATE  25.8824%     45.8824%    57.0588%    70.0000%    81.7647%    97.6471%   100.0000%   100.0000%
                                  44           78          97         119         139         166         170         170          50
 BILLING DATE - RCPT DATE   43.1953%     79.8817%    83.4320%    83.4320%    95.8580%    97.6331%   100.0000%   100.0000%
                                  73          135         141         141         162         165         169         169          32
 RECEIPT DATE - ADJ DATE    25.8824%     80.5882%    91.7647%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                  44          137         156         170         170         170         170         170          22
 RECEIPT DATE - CHECK DATE   2.3529%     72.3529%    91.1765%    91.7647%   100.0000%   100.0000%   100.0000%   100.0000%
                                   4          123         155         156         170         170         170         170          29

CHRISTIAN SCIENCE SANITORIUMS
 LAST SVC DATE - CHECK DATE   .0000%     12.5000%    75.0000%    87.5000%    87.5000%   100.0000%   100.0000%   100.0000%
                                   0            1           6           7           7           8           8           8          51
 LAST SVC DATE - ADJ DATE     .0000%     25.0000%    75.0000%    87.5000%    87.5000%   100.0000%   100.0000%   100.0000%
                                   0            2           6           7           7           8           8           8          47
 LAST SVC DATE - RCPT DATE    .0000%     75.0000%    87.5000%    87.5000%    87.5000%   100.0000%   100.0000%   100.0000%
                                   0            6           7           7           7           8           8           8          38
 LAST SVC DATE - BILL DATE  62.5000%     87.5000%    87.5000%    87.5000%    87.5000%   100.0000%   100.0000%   100.0000%
                                   5            7           7           7           7           8           8           8          23
 BILLING DATE - RCPT DATE   62.5000%    100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                   5            8           8           8           8           8           8           8          15
 RECEIPT DATE - ADJ DATE   100.0000%    100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                   8            8           8           8           8           8           8           8          10
 RECEIPT DATE - CHECK DATE 100.0000%    100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                   8            8           8           8           8           8           8           8          14
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WH06-00R

INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM
ALL CLAIM (UNIQUE LINE ITEM) PROCESSING THRUPUT ANALYSIS
MEDICARE CROSSOVERS NOT INCLUDED

DATE 06/10/80

SERVICES PROVIDERS	15 DAYS	30 DAYS	45 DAYS	60 DAYS	90 DAYS	100 DAYS	365 DAYS	365 PLUS	AVG. DAYS
CLINICS, INDEPENDENT									
LAST SVC DATE - CHECK DATE	.0000% 0	.0000% 0	50.0000% 12	87.5000% 21	95.8333% 23	100.0000% 24	100.0000% 24	100.0000% 24	47
LAST SVC DATE - ADJ DATE	.0000% 0	33.3333% 8	83.3333% 20	95.8333% 23	95.8333% 23	100.0000% 24	100.0000% 24	100.0000% 24	39
LAST SVC DATE - RCPT DATE	8.3333% 2	95.8333% 23	95.8333% 23	95.8333% 23	95.8333% 23	100.0000% 24	100.0000% 24	100.0000% 24	25
LAST SVC DATE - BILL DATE	58.3333% 14	95.8333% 23	100.0000% 24	100.0000% 24	100.0000% 24	100.0000% 24	100.0000% 24	100.0000% 24	12
BILLING DATE - RCPT DATE	90.4762% 19	95.2381% 20	95.2381% 20	95.2381% 20	100.0000% 21	100.0000% 21	100.0000% 21	100.0000% 21	16
RECEIPT DATE - ADJ DATE	79.1667% 19	100.0000% 24	100.0000% 24	100.0000% 24	100.0000% 24	100.0000% 24	100.0000% 24	100.0000% 24	14
RECEIPT DATE - CHECK DATE	.0000% 0	91.6667% 22	100.0000% 24	100.0000% 24	100.0000% 24	100.0000% 24	100.0000% 24	100.0000% 24	22
CLINICS, OUTPATIENT PSYCH.									
LAST SVC DATE - CHECK DATE	.0000% 0	1.5453% 14	11.1479% 101	23.1788% 210	51.6556% 468	81.4570% 738	96.9095% 878	100.0000% 906	121
LAST SVC DATE - ADJ DATE	.1104% 1	4.9669% 45	16.7770% 152	32.4503% 294	54.6358% 495	83.2230% 754	97.0199% 879	100.0000% 906	115
LAST SVC DATE - RCPT DATE	2.8690% 26	15.7837% 143	32.6711% 296	48.0132% 435	63.6865% 577	85.9823% 779	98.0132% 888	100.0000% 906	96
LAST SVC DATE - BILL DATE	29.2359% 264	46.1794% 417	56.9214% 514	66.3344% 599	75.3045% 680	88.8151% 802	98.3389% 888	100.0000% 903	70
BILLING DATE - RCPT DATE	46.3576% 420	72.4062% 656	85.3201% 773	91.3907% 828	96.7991% 877	99.0066% 897	100.0000% 906	100.0000% 906	27
RECEIPT DATE - ADJ DATE	51.8764% 470	85.5408% 775	97.1302% 880	100.0000% 906	100.0000% 906	100.0000% 906	100.0000% 906	100.0000% 906	19
RECEIPT DATE - CHECK DATE	8.4989% 77	77.0419% 698	95.2539% 863	99.3377% 900	100.0000% 906	100.0000% 906	100.0000% 906	100.0000% 906	25
DENTISTS									
LAST SVC DATE - CHECK DATE	.0000% 0	18.8321% 4,776	61.2594% 15,536	78.9086% 20,012	91.6762% 23,250	97.7209% 24,783	99.6372% 25,269	100.0000% 25,361	53
LAST SVC DATE - ADJ DATE	.2563% 65	41.2247% 10,455	71.6809% 18,179	83.6994% 21,227	92.6422% 23,495	97.8234% 24,809	99.6491% 25,272	100.0000% 25,361	46
LAST SVC DATE - RCPT DATE	47.2339% 11,979	75.2573% 19,086	85.2766% 21,627	90.6825% 22,998	95.1776% 24,138	98.1428% 24,890	99.6924% 25,283	100.0000% 25,361	29
LAST SVC DATE - BILL DATE	80.1530% 20,327	88.0560% 22,331	92.3738% 23,426	94.5899% 23,989	96.8612% 24,564	99.6593% 25.020	99.8186% 25,314	100.0000% 25,360	14
BILLING DATE - RCPT DATE	68.5311% 17,313	92.6295% 23,401	96.9362% 24,489	98.3652% 24,850	99.0698% 25,028	99.7744% 25.206	99.9406% 25,248	100.0000% 25,263	16
RECEIPT DATE - ADJ DATE	42.7546% 10,843	93.3935% 23.683	99.5544% 25,248	99.9921% 25,359	100.0000% 25,361	100.0000% 25,361	100.0000% 25,361	100.0000% 25,361	17
RECEIPT DATE - CHECK DATE	4.7474% 1,204	86.0849% 21.832	98.5411% 24,991	99.8502% 25,323	100.0000% 25,361	100.0000% 25,361	100.0000% 25,361	100.0000% 25,361	24

INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM
ALL CLAIM (UNIQUE LINE ITEM) PROCESSING THRUPUT ANALYSIS
MEDICARE CROSSOVERS NOT INCLUDED

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SERVICES PROVIDERS          15   DAYS   30   DAYS   45   DAYS   60   DAYS   90   DAYS   180  DAYS   365  DAYS   365  PLUS   AVG. DAYS

DISPENSING OPTICIANS
 LAST SVC DATE - CHECK DATE   .0000%      3.8055%     41.6490%     70.4017%     94.2918%     99.1543%    100.0000%    100.0000%
                                   0           18          197          333          446          469          473          473         55
 LAST SVC DATE - ADJ DATE     .0000%     17.5476%     52.0085%     79.4926%     95.5603%     99.1543%    100.0000%    100.0000%
                                   0           83          246          376          452          469          473          473         49
 LAST SVC DATE - RCPT DATE  21.7759%     67.2304%     85.6237%     91.7548%     96.8288%     99.5772%    100.0000%    100.0000%
                                 103          318          405          434          458          471          473          473         30
 LAST SVC DATE - BILL DATE  61.8337%     85.9275%     95.7356%     97.6546%     98.9339%    100.0000%    100.0000%    100.0000%
                                 290          403          449          458          464          469          469          469         16
 BILLING DATE - RCPT DATE   62.8959%     86.1991%     95.9276%     97.2851%     99.0950%    100.0000%    100.0000%    100.0000%
                                 278          381          424          430          438          442          442          442         16
 RECEIPT DATE - ADJ DATE    20.7188%     91.1205%     99.3658%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                                  98          431          470          473          473          473          473          473         19
 RECEIPT DATE - CHECK DATE   2.1142%     78.2241%     98.7315%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                                  10          370          467          473          473          473          473          473         25

FAMILY PLANNING AGENCIES
 LAST SVC DATE - CHECK DATE   .0000%      8.7174%     45.8918%     73.1463%     90.3808%     99.2986%    100.0000%    100.0000%
                                   0           87          458          730          902          991          998          998         55
 LAST SVC DATE - ADJ DATE     .0000%     18.1363%     62.2244%     79.2585%     91.3828%     99.2986%    100.0000%    100.0000%
                                   0          181          621          791          912          991          998          998         49
 LAST SVC DATE - RCPT DATE  33.3667%     64.6293%     81.1623%     89.7796%     95.7916%     99.7996%    100.0000%    100.0000%
                                 333          645          810          896          956          996          998          998         31
 LAST SVC DATE - BILL DATE  70.6413%     86.1723%     93.1864%     96.7936%     98.2966%     99.7996%    100.0000%    100.0000%
                                 705          860          930          966          981          996          998          998         14
 BILLING DATE - RCPT DATE   59.2161%     84.4280%     91.6314%     94.3856%     97.7754%    100.0000%    100.0000%    100.0000%
                                 559          797          865          891          923          944          944          944         19
 RECEIPT DATE - ADJ DATE    37.1743%     93.6874%     99.5992%     99.6994%    100.0000%    100.0000%    100.0000%    100.0000%
                                 371          935          994          995          998          998          998          998         18
 RECEIPT DATE - CHECK DATE  11.0220%     85.2705%     96.8938%     99.6994%    100.0000%    100.0000%    100.0000%    100.0000%
                                 110          851          967          995          998          998          998          998         24

HEALTH MAINTENANCE ORGANIZATION
 LAST SVC DATE - CHECK DATE   .0000%       .0000%       .0000%       .0000%       .0000%       .0000%       .0000%       .0000%
                                   0            0            0            0            0            0            0            0
 LAST SVC DATE - ADJ DATE     .0000%       .0000%       .0000%       .0000%       .0000%       .0000%       .0000%       .0000%
                                   0            0            0            0            0            0            0            0
 LAST SVC DATE - RCPT DATE    .0000%       .0000%       .0000%       .0000%       .0000%       .0000%       .0000%       .0000%
                                   0            0            0            0            0            0            0            0
 LAST SVC DATE - BILL DATE    .0000%       .0000%       .0000%       .0000%       .0000%       .0000%       .0000%       .0000%
                                   0            0            0            0            0            0            0            0
 BILLING DATE - RCPT DATE     .0000%       .0000%       .0000%       .0000%       .0000%       .0000%       .0000%       .0000%
                                   0            0            0            0            0            0            0            0
 RECEIPT DATE - ADJ DATE      .0000%       .0000%       .0000%       .0000%       .0000%       .0000%       .0000%       .0000%
                                   0            0            0            0            0            0            0            0
 RECEIPT DATE - CHECK DATE    .0000%       .0000%       .0000%       .0000%       .0000%       .0000%       .0000%       .0000%
                                   0            0            0            0            0            0            0            0
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INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM
ALL CLAIM (UNIQUE LINE ITEM) PROCESSING THRUPUT ANALYSIS
MEDICARE CROSSOVERS NOT INCLUDED

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SERVICES PROVIDERS          15   DAYS    30   DAYS    45   DAYS    60   DAYS    90   DAYS   180  DAYS   365  DAYS   365  PLUS   AVG. DAYS

LABS & XRAYS, INDEPENDENT
 LAST SVC DATE - CHECK DATE  .0000%     14.4023%     47.1720%     63.1195%     78.5131%     94.5773%     99.4752%    100.0000%
                                  0          494        1,618        2,165        2,693        3,244        3,412        3,430          72
 LAST SVC DATE - ADJ DATE    .1458%     27.4344%     57.0554%     67.8426%     79.9125%     94.8688%     99.4752%    100.0000%
                                  5          941        1,957        2,327        2,741        3,254        3,412        3,430          65
 LAST SVC DATE - RCPT DATE 24.2566%     61.1370%     69.8251%     77.0262%     83.4111%     95.5977%     99.7668%    100.0000%
                                832        2,097        2,395        2,642        2,861        3,279        3,422        3,430          49
 LAST SVC DATE - BILL DATE 61.7561%     74.9417%     82.0595%     84.5974%     89.7608%     96.5869%     99.8833%    100.0000%
                              2,117        2,569        2,813        2,900        3,077        3,311        3,424        3,428          31
 BILLING DATE - RCPT DATE  62.2356%     89.6677%     92.2961%     95.5589%     98.0363%     99.7583%     99.9094%    100.0000%
                              2,060        2,968        3,055        3,163        3,245        3,302        3,307        3,310          20
 RECEIPT DATE - ADJ DATE   57.7843%     92.6239%     98.7172%     99.6793%     99.9708%    100.0000%    100.0000%    100.0000%
                              1,982        3,177        3,386        3,419        3,429        3,430        3,430        3,430          17
 RECEIPT DATE - CHECK DATE 10.0875%     82.5656%     97.5802%     99.5335%     99.9708%    100.0000%    100.0000%    100.0000%
                                346        2,832        3,347        3,414        3,429        3,430        3,430        3,430          23

MENTAL HEALTH CENTERS, COMMUNITY
 LAST SVC DATE - CHECK DATE  .0000%       .0000%       .0000%     11.7647%     94.1176%    100.0000%    100.0000%    100.0000%
                                  0            0            0            2           16           17           17           17          74
 LAST SVC DATE - ADJ DATE    .0000%       .0000%      5.8824%     35.2941%    100.0000%    100.0000%    100.0000%    100.0000%
                                  0            0            1            6           17           17           17           17          64
 LAST SVC DATE - RCPT DATE   .0000%       .0000%     23.5294%     88.2353%    100.0000%    100.0000%    100.0000%    100.0000%
                                  0            0            4           15           17           17           17           17          52
 LAST SVC DATE - BILL DATE   .0000%     29.4118%     94.1176%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                                  0            5           16           17           17           17           17           17          34
 BILLING DATE - RCPT DATE    .0000%     88.2353%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                                  0           15           17           17           17           17           17           17          19
 RECEIPT DATE - ADJ DATE   70.5882%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                                 12           17           17           17           17           17           17           17          13
 RECEIPT DATE - CHECK DATE   .0000%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                                  0           17           17           17           17           17           17           17          22

NURSES, PRIVATE
 LAST SVC DATE - CHECK DATE  .0000%      7.4074%     14.8148%     40.7407%     77.7770%     88.8889%    100.0000%    100.0000%
                                  0            2            4           11           21           24           27           27          82
 LAST SVC DATE - ADJ DATE   3.7037%     11.1111%     37.0370%     48.1481%     81.4815%     92.5926%    100.0000%    100.0000%
                                  1            3           10           13           22           25           27           27          74
 LAST SVC DATE - RCPT DATE 14.8148%     44.4444%     55.5556%     66.6667%     81.4815%     96.2963%    100.0000%    100.0000%
                                  4           12           15           18           22           26           27           27          57
 LAST SVC DATE - BILL DATE 61.5385%     76.9231%     76.9231%     80.7692%     84.6154%    100.0000%    100.0000%    100.0000%
                                 16           20           20           21           22           26           26           26          31
 BILLING DATE - RCPT DATE  22.2222%     66.6667%     74.0741%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                                  6           18           20           27           27           27           27           27          28
 RECEIPT DATE - ADJ DATE   37.0370%     92.5926%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                                 10           25           27           27           27           27           27           27          18
 RECEIPT DATE - CHECK DATE   .0000%     85.1852%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%    100.0000%
                                  0           23           27           27           27           27           27           27          25
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WM06-09R                         INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                                  DATE 06/10/80
                              ALL CLAIM (UNIQUE LINE ITEM) PROCESSING THRUPUT ANALYSIS                           PAGE  16
                                           MEDICARE CROSSOVERS NOT INCLUDED

SERVICES PROVIDERS           15   DAYS   30   DAYS   45   DAYS   60   DAYS   90   DAYS  100  DAYS  365  DAYS  365  PLUS  AVG. DAYS

OPTOMETRISTS
 LAST SVC DATE - CHECK DATE   .0000%     8.5900%    32.9564%    59.4642%    86.7822%    96.1181%    99.5990%   100.0000%
                                   0       1,071       4,109       7,414      10,820      11,984      12,418      12,468        68
 LAST SVC DATE - ADJ DATE     .8422%    17.2201%    44.3054%    69.4257%    88.3301%    96.2223%    99.5990%   100.0000%
                                 105       2,148       5,524       8,656      11,013      11,997      12,418      12,468        61
 LAST SVC DATE - RCPT DATE  21.1582%    53.3125%    74.3904%    85.1941%    92.1070%    96.7757%    99.7995%   100.0000%
                               2,638       6,647       9,275      10,622      11,484      12,066      12,443      12,468        43
 LAST SVC DATE - BILL DATE  54.2294%    75.2515%    85.3280%    90.0169%    93.7384%    97.6821%    99.8873%   100.0000%
                               6,738       9,350      10,602      11,284      11,647      12,137      12,411      12,425        27
 BILLING DATE - RCPT DATE   67.3596%    87.2171%    94.1073%    97.7117%    98.8349%    99.6060%    99.9497%   100.0000%
                               8,036      10,405      11,227      11,657      11,791      11,883      11,924      11,930        17
 RECEIPT DATE - ADJ DATE    31.3442%    90.5518%    99.1338%    99.9278%   100.0000%   100.0000%   100.0000%   100.0000%
                               3,908      11,290      12,360      12,459      12,468      12,468      12,468      12,468        19
 RECEIPT DATE - CHECK DATE   5.0690%    83.8707%    97.3693%    99.8476%   100.0000%   100.0000%   100.0000%   100.0000%
                                 632      10,457      12,140      12,449      12,468      12,468      12,468      12,468        25

OSTEOPATHS
 LAST SVC DATE - CHECK DATE   .0654%    13.7435%    43.7827%    58.4424%    75.7199%    95.2225%    99.8691%   100.0000%
                                   1         210         669         893       1,157       1,455       1,526       1,528        69
 LAST SVC DATE - ADJ DATE    1.4398%    28.7958%    52.0288%    64.7251%    79.7120%    95.4188%    99.8691%   100.0000%
                                  22         440         795         989       1,218       1,458       1,526       1,528        62
 LAST SVC DATE - RCPT DATE  28.0105%    53.7304%    65.7068%    74.2147%    84.4895%    96.0733%   100.0000%   100.0000%
                                 428         821       1,004       1,134       1,291       1,468       1,528       1,528        47
 LAST SVC DATE - BILL DATE  53.0105%    66.4921%    74.5419%    80.8901%    90.6414%    96.7277%   100.0000%   100.0000%
                                 810       1,016       1,139       1,236       1,385       1,478       1,528       1,528        33
 BILLING DATE - RCPT DATE   68.3544%    90.8579%    97.9606%    98.6639%    99.4374%    99.6484%   100.0000%   100.0000%
                                 972       1,292       1,393       1,403       1,414       1,417       1,422       1,422        16
 RECEIPT DATE - ADJ DATE    61.4529%    94.5026%    99.8037%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                 939       1,444       1,525       1,528       1,528       1,528       1,528       1,528        16
 RECEIPT DATE - CHECK DATE   9.3586%    86.9764%    98.4293%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                 143       1,329       1,504       1,528       1,528       1,528       1,528       1,528        22

PHARMACISTS
 LAST SVC DATE - CHECK DATE  6.0971%    44.5533%    73.6762%    85.9162%    93.6126%    97.8355%    99.6728%   100.0000%
                              17,831     130,296     215,466     251,262     273,770     286,120     291,493     292,450        44
 LAST SVC DATE - ADJ DATE   13.9638%    60.5805%    81.0631%    88.7270%    94.2305%    97.9672%    99.6851%   100.0000%
                              40,837     177,191     237,069     259,482     275,577     286,505     291,529     292,450        38
 LAST SVC DATE - RCPT DATE  53.4139%    79.3807%    88.0397%    92.0725%    95.1004%    98.2158%    99.7117%   100.0000%
                             156,209     232,149     257,472     269,266     278,121     287,232     291,607     292,450        27
 LAST SVC DATE - BILL DATE  77.6806%    89.3660%    92.9598%    94.7598%    96.3843%    98.6181%    99.7762%   100.0000%
                             223,888     257,567     267,925     273,113     277,795     284,233     287,571     288,216        16
 BILLING DATE - RCPT DATE   81.1577%    93.3370%    96.3161%    97.7559%    98.6164%    99.3149%    99.5480%   100.0000%
                             230,880     265,528     274,003     278,099     280,547     282,534     283,197     284,483        83
 RECEIPT DATE - ADJ DATE    87.2577%    99.2091%    99.9925%    99.9962%    99.9962%   100.0000%   100.0000%   100.0000%
                             255,185     290,137     292,428     292,439     292,439     292,450     292,450     292,450        11
 RECEIPT DATE - CHECK DATE  36.6507%    93.1041%    99.9456%    99.9959%    99.9962%   100.0000%   100.0000%   100.0000%
                             107,185     272,283     292,291     292,438     292,439     292,450     292,450     292,450        17
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WM06-00R                         INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                                   DATE 06/10/80
                              ALL CLAIM (UNIQUE LINE ITEM) PROCESSING THRUPUT ANALYSIS                            PAGE  17
                                          MEDICARE CROSSOVERS NOT INCLUDED

SERVICES PROVIDERS          15   DAYS   30   DAYS   45   DAYS   60   DAYS   90   DAYS   100  DAYS   365  DAYS   365  PLUS   AVG. DAYS

PHYSICIANS
 LAST SVC DATE - CHECK DATE    .0084%    13.7717%    43.6843%    62.7116%    79.4570%    92.9391%    98.7937%   100.0000%
                                   6        9,795      31,070      44,603      56,513      66,102      70,266      71,124         74
 LAST SVC DATE - ADJ DATE      .5230%    26.9909%    54.1294%    68.5057%    81.2609%    93.4663%    98.8625%   100.0000%
                                 372       19,197      38,499      48,724      57,796      66,477      70,315      71,124         67
 LAST SVC DATE - RCPT DATE   25.7058%    57.0595%    70.7145%    77.9104%    85.4494%    94.7430%    99.0538%   100.0000%
                              18,283       40,583      50,295      55,413      60,775      67,385      70,451      71,124         51
 LAST SVC DATE - BILL DATE   60.5384%    75.0666%    81.2104%    84.9599%    89.6527%    96.1250%    99.3260%   100.0000%
                              42,932       53,235      57,592      60,251      63,579      68,169      70,439      70,917         33
 BILLING DATE - RCPT DATE    61.5634%    88.1559%    93.6344%    96.2987%    98.0148%    99.4270%    99.8938%   100.0000%
                              42,331       60,616      64,383      66,215      67,395      68,366      68,687      68,760         22
 RECEIPT DATE - ADJ DATE     57.7752%    91.8002%    98.6418%    99.6991%    99.9888%   100.0000%   100.0000%   100.0000%
                              41,092       65,292      70,158      70,910      71,116      71,124      71,124      71,124         17
 RECEIPT DATE - CHECK DATE    9.7225%    83.0901%    96.8506%    99.4868%    99.9888%   100.0000%   100.0000%   100.0000%
                               6,915       59,097      68,884      70,759      71,116      71,124      71,124      71,124         24

PODIATRISTS
 LAST SVC DATE - CHECK DATE    .0000%    13.7654%    39.8765%    55.8025%    73.8272%    91.1111%    98.1481%   100.0000%
                                   0          223         646         904       1,196       1,476       1,590       1,620         85
 LAST SVC DATE - ADJ DATE      .3086%    25.0617%    47.6543%    61.4198%    76.2346%    91.4198%    98.2099%   100.0000%
                                   5          406         772         995       1,235       1,481       1,591       1,620         79
 LAST SVC DATE - RCPT DATE   18.8889%    54.1975%    63.3951%    73.2099%    81.4198%    92.7160%    98.3333%   100.0000%
                                 306          878       1,027       1,186       1,319       1,502       1,593       1,620         62
 LAST SVC DATE - BILL DATE   62.1755%    69.6539%    76.2052%    80.2843%    86.0939%    93.8195%    98.5785%   100.0000%
                               1,006        1,127       1,233       1,299       1,393       1,518       1,595       1,618         43
 BILLING DATE - RCPT DATE    39.6845%    88.0126%    94.3849%    97.4763%    98.8013%    99.8738%   100.0000%   100.0000%
                                 629        1,395       1,496       1,545       1,566       1,583       1,585       1,585         20
 RECEIPT DATE - ADJ DATE     49.6914%    88.5802%    97.9012%    99.8148%   100.0000%   100.0000%   100.0000%   100.0000%
                                 805        1,435       1,586       1,617       1,620       1,620       1,620       1,620         17
 RECEIPT DATE - CHECK DATE   14.6296%    81.5432%    95.9259%    99.3827%   100.0000%   100.0000%   100.0000%   100.0000%
                                 237        1,321       1,554       1,610       1,620       1,620       1,620       1,620         24

PSYCHOLOGISTS
 LAST SVC DATE - CHECK DATE    .0000%    10.0313%    28.5266%    49.2163%    75.5486%    91.8495%    97.8056%   100.0000%
                                   0           32          91         157         241         293         312         319         83
 LAST SVC DATE - ADJ DATE     1.2539%    17.2414%    39.8119%    57.9937%    79.6238%    93.7304%    97.8056%   100.0000%
                                   4           55         127         185         254         299         312         319         76
 LAST SVC DATE - RCPT DATE   13.1661%    42.9467%    58.3072%    71.4734%    84.0125%    94.6708%    97.8056%   100.0000%
                                  42          137         186         228         268         302         312         319         61
 LAST SVC DATE - BILL DATE   47.0219%    63.6364%    74.9216%    80.5643%    89.0282%    95.6113%    98.1191%   100.0000%
                                 150          203         239         257         284         305         313         319         43
 BILLING DATE - RCPT DATE    52.8481%    92.0886%    93.6709%    95.5696%    99.0506%   100.0000%   100.0000%   100.0000%
                                 167          291         296         302         313         316         316         316         18
 RECEIPT DATE - ADJ DATE     66.1442%    94.9843%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                 211          303         319         319         319         319         319         319         16
 RECEIPT DATE - CHECK DATE    4.3887%    85.8934%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                  14          274         319         319         319         319         319         319         23
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INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM
ALL CLAIM (UNIQUE LINE ITEM) PROCESSING THRUPUT ANALYSIS
MEDICARE CROSSOVERS NOT INCLUDED

SERVICES PROVIDERS	15 DAYS	30 DAYS	45 DAYS	60 DAYS	90 DAYS	180 DAYS	365 DAYS	365 PLUS	AVG. DAYS
TRANSPORTATION, MEDICAL									
LAST SVC DATE - CHECK DATE	.0237% 3	18.4373% 2,336	49.9921% 6,334	72.7309% 9,215	89.8421% 11,383	96.1721% 12,185	99.4475% 12,600	100.0000% 12,670	59
LAST SVC DATE - ADJ DATE	1.0576% 134	32.3283% 4,096	61.8232% 7,833	79.8343% 10,115	91.0103% 11,531	96.3536% 12,208	99.4949% 12,606	100.0000% 12,670	53
LAST SVC DATE - RCPT DATE	29.5501% 3,744	65.2486% 8,267	81.1523% 10,282	88.1926% 11,174	92.7703% 11,754	96.7245% 12,255	99.5975% 12,619	100.0000% 12,670	38
LAST SVC DATE - BILL DATE	62.8147% 7,958	78.3961% 9,932	88.7284% 11,241	92.1935% 11,680	94.4037% 11,960	97.4663% 12,348	99.7001% 12,631	100.0000% 12,669	25
BILLING DATE - RCPT DATE	72.8502% 8,785	95.0742% 11,465	97.7942% 11,793	98.5400% 11,883	98.9883% 11,937	99.6351% 12,015	99.9254% 12,050	100.0000% 12,059	14
RECEIPT DATE - ADJ DATE	52.4073% 6,640	95.2328% 12,066	99.5185% 12,609	100.0000% 12,670	100.0000% 12,670	100.0000% 12,670	100.0000% 12,670	100.0000% 12,670	16
RECEIPT DATE - CHECK DATE	15.6275% 1,980	87.7585% 11,119	98.5951% 12,492	99.9132% 12,659	100.0000% 12,670	100.0000% 12,670	100.0000% 12,670	100.0000% 12,670	22
THERAPISTS, INDEPENDENT PHYSICAL									
LAST SVC DATE - CHECK DATE	2.5388% 36	16.1495% 229	38.8575% 551	81.8759% 1,161	98.8011% 1,401	99.3653% 1,409	100.0000% 1,418	100.0000% 1,418	48
LAST SVC DATE - ADJ DATE	5.5007% 78	25.9520% 368	66.0790% 937	95.0635% 1,348	98.8717% 1,402	99.3653% 1,409	100.0000% 1,418	100.0000% 1,418	40
LAST SVC DATE - RCPT DATE	31.3822% 445	76.3047% 1,082	97.4612% 1,382	98.5190% 1,397	99.0832% 1,405	99.6474% 1,413	100.0000% 1,418	100.0000% 1,418	23
LAST SVC DATE - BILL DATE	47.2496% 670	96.8970% 1,374	98.7306% 1,400	99.2243% 1,407	99.4358% 1,410	100.0000% 1,418	100.0000% 1,418	100.0000% 1,418	16
BILLING DATE - RCPT DATE	96.4739% 1,368	98.6601% 1,399	99.2243% 1,407	99.2243% 1,407	99.7179% 1,414	100.0000% 1,418	100.0000% 1,418	100.0000% 1,418	7
RECEIPT DATE - ADJ DATE	58.3216% 827	71.3681% 1,012	100.0000% 1,418	100.0000% 1,418	100.0000% 1,418	100.0000% 1,418	100.0000% 1,418	100.0000% 1,418	17
RECEIPT DATE - CHECK DATE	21.2976% 302	70.4513% 999	93.9351% 1,332	100.0000% 1,418	100.0000% 1,418	100.0000% 1,418	100.0000% 1,418	100.0000% 1,418	25
THERAPISTS, INDEPENDENT SPEECH									
LAST SVC DATE - CHECK DATE	.0000% 0	6.7114% 10	43.6242% 65	83.2215% 124	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	49
LAST SVC DATE - ADJ DATE	.0000% 0	12.0805% 18	55.7047% 83	89.9329% 134	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	43
LAST SVC DATE - RCPT DATE	13.4228% 20	42.2819% 63	93.9597% 140	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	28
LAST SVC DATE - BILL DATE	89.9329% 134	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	5
BILLING DATE - RCPT DATE	23.4899% 35	69.7987% 104	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	24
RECEIPT DATE - ADJ DATE	44.2953% 66	97.3154% 145	98.6577% 147	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	16
RECEIPT DATE - CHECK DATE	23.4899% 35	93.2886% 139	98.6577% 147	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	100.0000% 149	21

INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM
ALL CLAIM (UNIQUE LINE ITEM) PROCESSING THRUPUT ANALYSIS
MEDICARE CROSSOVERS NOT INCLUDED

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SUPPLIES PROVIDERS            15  DAYS    30  DAYS    45  DAYS    60  DAYS    90  DAYS   100  DAYS   365  DAYS   365  PLUS   AVG. DAYS

MEDICAL EQUIPMENT SUPPLIES
 LAST SVC DATE - CHECK DATE   .0000%     9.6188%    43.6364%    67.3314%    88.7977%    97.0674%    99.6481%   100.0000%
                                   0         164         744       1,148       1,514       1,655       1,699       1,705          60
 LAST SVC DATE - ADJ DATE     .7625%    22.1701%    56.4809%    76.0117%    90.6745%    97.1848%    99.6481%   100.0000%
                                  13         378         963       1,296       1,546       1,657       1,699       1,705          54
 LAST SVC DATE - RCPT DATE  31.4956%    64.6334%    80.2933%    88.0352%    93.1965%    97.9472%    99.7067%   100.0000%
                                 537       1,102       1,369       1,501       1,589       1,670       1,700       1,705          35
 LAST SVC DATE - BILL DATE  66.6466%    83.1427%    90.4275%    92.5346%    95.4846%    98.9163%    99.9398%   100.0000%
                               1,107       1,381       1,502       1,537       1,586       1,643       1,660       1,661          19
 BILLING DATE - RCPT DATE   61.6229%    87.7974%    94.7529%    97.6815%    99.0848%    99.5729%    99.7559%   100.0000%
                               1,010       1,439       1,553       1,601       1,624       1,632       1,635       1,639          18
 RECEIPT DATE - ADJ DATE    30.7918%    90.0880%    98.9443%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                 525       1,536       1,687       1,705       1,705       1,705       1,705       1,705          19
 RECEIPT DATE - CHECK DATE   8.0938%    78.9443%    96.2463%    99.6481%   100.0000%   100.0000%   100.0000%   100.0000%
                                 138       1,346       1,641       1,699       1,705       1,705       1,705       1,705          26

PROSTHETIC DEVICE SUPPLIES
 LAST SVC DATE - CHECK DATE   .0000%     2.7778%    36.1111%    82.4074%    93.5185%    99.0741%   100.0000%   100.0000%
                                   0           3          39          89         101         107         108         108          54
 LAST SVC DATE - ADJ DATE     .0000%    22.2222%    57.4074%    83.3333%    98.1481%    99.0741%   100.0000%   100.0000%
                                   0          24          62          90         106         107         108         108          48
 LAST SVC DATE - RCPT DATE  22.2222%    73.1481%    92.5926%    95.3704%    99.0741%    99.0741%   100.0000%   100.0000%
                                  24          79         100         103         107         107         108         108          28
 LAST SVC DATE - BILL DATE  79.6296%    87.9630%    93.5185%    96.2963%    99.0741%    99.0741%   100.0000%   100.0000%
                                  86          95         101         104         107         107         108         108          13
 BILLING DATE - RCPT DATE   68.5185%    93.5185%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                  74         101         108         108         108         108         108         108          15
 RECEIPT DATE - ADJ DATE    26.8519%    75.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                  29          81         108         108         108         108         108         108          21
 RECEIPT DATE - CHECK DATE  12.9630%    67.5926%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                  14          73         108         108         108         108         108         108          27

HEARING AID DEALERS
 LAST SVC DATE - CHECK DATE   .0000%     5.1118%    47.2843%    69.0096%    88.8179%    98.0831%    99.6805%   100.0000%
                                   0          16         148         216         278         307         312         313          59
 LAST SVC DATE - ADJ DATE     .0000%    26.1981%    60.7029%    74.4409%    89.1374%    98.4026%    99.6805%   100.0000%
                                   0          82         190         233         279         308         312         313          53
 LAST SVC DATE - RCPT DATE  21.7252%    61.6613%    76.3578%    86.9010%    92.6518%    98.7220%   100.0000%   100.0000%
                                  68         193         239         272         290         309         313         313          37
 LAST SVC DATE - BILL DATE  63.2588%    78.9137%    87.8594%    89.4569%    95.2077%    98.7220%   100.0000%   100.0000%
                                 198         247         275         280         298         309         313         313          22
 BILLING DATE - RCPT DATE   58.6538%    92.9487%    98.7179%    99.3590%    99.6795%   100.0000%   100.0000%   100.0000%
                                 183         290         308         310         311         312         312         312          16
 RECEIPT DATE - ADJ DATE    41.8530%    97.4441%    98.7220%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                 131         305         309         313         313         313         313         313          16
 RECEIPT DATE - CHECK DATE  14.0575%    92.9712%    98.0831%   100.0000%   100.0000%   100.0000%   100.0000%   100.0000%
                                  44         291         307         313         313         313         313         313          22
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ALL OTHER PROVIDERS         15   DAYS   30   DAYS   45   DAYS   60   DAYS   90   DAYS   100  DAYS   365  DAYS   365  PLUS   AVG. DAYS

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RECORD TYPE=F,LENGTH=(00056)
WER055I  INSERT      448, DELETE      448
WER177I  TURNAROUND SORT PERFORMED
WER045C  END SORT PH
WER246I  FILESIZE 25,008 BYTES
WER054I  RCD IN        0, OUT        0
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REPORT ON INVENTORY OF STATE INFORMATION SYSTEMS

Karl Vorlander
Executive Director
National Association of State
Information Systems

MR. VORLANDER: Before I came here, I went over the agenda. And since I speak for the central data processing administrators in the States, I thought maybe I would find a familiar name. The only one I found was G. Warren Peterson. And I thought, after reading that, that I was probably a stranger to most of you, and it was apparent that most of you are strangers to me. And that could be a dangerous situation.

So, I ought to tell you a little about what NASIS is. Our background goes back to 1965 when Governor Romney called a meeting in Lansing to talk about the need to get some kind of a handle on data processing. It was proliferating at a horrendous pace. Costs were skyrocketing. The National Governors' Conference found out about this meeting that he was going to have for State people, and they asked to cosponsor it for all 50 States. The meeting was held, and out of that came a very small group, the Ad Hoc Committee on Technology and Information Systems. There were about 13 of us. And we went on for about four years, and then we had a meeting in Washington, and decided that 13 people from 13 scattered States couldn't go aound making policy statements or taking positions for all 50 States. So, in 1969, NASIS was created. I guess our work is best expressed by the five standing committees. We have one on standards, which, by the way, has just published a report, which should be in the mail today or tomorrow to our prime contacts -- and I will explain them in a moment -- on HEW billing requirements.

One of the real problems that many States are having right now, and which we are fighting with OMB, is the disallowance of interest costs for computer acquisitions as a proper overhead cost. It is being disallowed, and it is being challenged in Minnesota. It has been challenged in Oregon.

OMB is going to change FMC-74-4, we are told, to permit interest costs on capital construction for new buildings, but they will not, at this point, change it for acquisition of computers. And it depends on the vendor you have got, whether he must show interest as a separate item. In some cases, where their own financing is involved, they must show interest as a separate item in their billing to the customer, and that interest is not a recoverable cost. At least one State in the last two weeks has switched from a third party lease purchase to a third party straight lease. Our study shows that if all the States have to do this, it will be an increased cost of about $30 million. So much for the Standards Committee. Research and Education has published some studies on productivity aids that are in use by various States, their appraisal of them. We are doing some work on curriculum types of things. Federal, State, and local is just that. It's a liaison committee. It's the reason I have served on several of the Federal task forces. It is the mechanism by which we are dealing with OMB. And another item, I should tell you, that is out to the Federal agencies as of the 8th of this month, is a memorandum from McIntyre of OMB, which will establish the Federal Aid Management Information System.

Many of you may have gone through FACS, the old Federal Aid Control System, REGIS, which was a monstrosity created by somebody. The new system is a device whereby States will be informed of all Federal monies, all Federal aids flowing into that State on a quarterly basis within four to six weeks after that grant proposal has been approved. It is going to be called FAMIS. Right now, 13 agencies are involved. It is going to go to all 50 States October 1. Again, you will be able to read that directive from the State's prime contact. Let me skip out to our prime contact. There is a prime contact for each branch of State government in all States except the

State of Texas, where the Governor some years ago wiped him out. Copies of all of our reports go to each prime contact. I will leave a copy of our annual report here, which has the list in it. It's not quite current because turnover is pretty rapid in the information systems business. But all the reports are available from those prime contacts. We have an interbranch liaison, which is an attempt to get all three branches talking to each other. We have varying degrees of response to that. In some States, through political history, the executive branch doesn't talk to the legislative branch, and the courts are above all of that sort of thing.

We publish an annual report, which is compiled from information supplied by the States, and this is what they asked me to talk about. I think most of you probably read Doonesbury. I feel a little bit like Zeke Brenner up here, touting our latest publication. But it's not Zeke's biography; it's the information systems technology in State government. It is put out every year. The executive branch prime contact has an extra copy of this report intended as a loan copy, as a library copy. There is a description in it saying what NASIS is doing. There are a series of observations in it about what happened in State governments. There is a snapshot of coordination and control, computer inventory and personnel. Many of these are not by States; they are done by aggregates, for obvious reasons. But there are some salary maximums and minimums. There are: 1) numbers of personnel, types of personnel, and consultants; 2) training, methods of training, and types of training; 3) whether a State has a plan and standards, 4) what the intergovernmental relationships are, 5) whether the State has responsibility for data processing activities in the education or welfare fields, the management of the information function, what types of reports there are, what is available; 6) funding, what the costs are of data processing as compared to the overall costs of State government, how they are charged, whether they charge back or there is an appropriation; and, 7) finally, security and privacy. And, by the way, we have a standing committee on that, and it's a very hot issue.

We developed a model State act, which was published by the Committee on suggested State legislation. A great deal of it was based on Minnesota law, which was one of the first ones. It has been used in about seven other States. Our concern was that the data processing or information systems administrator may be honest, but political pressures can be brought. We would like to know what kind of recipients we have in certain States, other things. And when you are sitting there, as I did in Wisconsin, with the vital statistics files, venereal disease, unwed mothers, welfare recipients, income tax returns, you can get very uncomfortable if somebody starts saying "I want this," and you have no choice but to say "I quit," and eventually somebody would come in who would release that. So, privacy is one of our genuine concerns.

Finally, a history of transfer projects, who transferred what from what State to what State is included. The other items in there, that I think would be of interest to you, are two of the appendices. One is an appendix of applications. It has a matrix in the front end that talks about 127 application areas. For mental health, it has such things as patient census, hospital administration systems, patient information systems, and menu planning. In welfare, it would have central persons index, application assistance, eligibility determination, grant computation, case record maintenance, warrant writing, payment in kind, Medicaid's eligibility determination, vendor payment, utilization and surveillance, Federal reports, caseload management, administration, food stamps, vocational rehab, nursing home registration, and foster homes. The matrix will tell you what State has it automated. If you go back to that State, look up the application, it will tell you what kind of hardware it runs on, what operating system is being used, whether it is on line or batch, what type of storage, and also whether the State considers it transferable. And by "transferable," we are talking about sufficient documentation.

And we are no different, States are no different than private industry and everybody else. A programmer loves to code, but when you make him/her sit down and try to write the documentation and the operator instructions, it is just like pulling teeth. So, there is the question of documentation. It's put together by the prime contacts, and there is some question in my mind even about the validity of some of the information. In some cases, it is extremely good. In some cases, they leave out a whole department. I don't think there is a transportation department in the United States that doesn't have some kind of automation, whether they use a central service bureau or have their own inhouse installation, but I have noted States that have left out the whole transportation department.

The question of how the survey is done is left up to the State. We compile them, put it together. The new report should be out in about two weeks. The information is generally based on July 1. It takes us about six months to get the information, and about three more months before we get the stragglers. And it does contain information on all 50 States.

One interesting fact this year is the increase in the use of consultants. We are not sure what is happening, whether it is the labor market. If you use Computer World as a guide, you can go count the number of pages of want ads for data processing personnel, and they have about tripled. Another question is how much are they using consultants to put in packages. But consultant costs have gone up rather significantly over the last three years.

I think that is about enough on the annual report. I will leave it here. The list of prime contacts are in the back. Or you can write me; my address is P.O. Box 11910, Lexington, Kentucky, 40578. The telephone is Area Code 606-252-2291.

We have two other publications that I should tell you about. We have a newsletter that goes out quarterly, which carries the major stories of new accomplishments, new Federal activity. We also publish a monthly bulletin, which is intended as a means to let States ask for assistance, or to tell of new immediate developments, new publications that are out, new Federal regulations.

The membership of NASIS is open to any person in the State who has any interest in information systems. The State itself is the member. The voting is done, one State, one vote; but, the vote is divided by representatives of the three branches present and voting. Any employee of that State is welcome to give me a call, write me a letter, ask that something be put in the bulletin, ask for any information which, hopefully, we can provide.

I talked about transferability, and it is one of those things that is very important to us. One State, that has management by objectives, had the various managers of the different units of the central installation, have their merit increases based on whether they had considered transferability where it was available, had considered the feasibility, and, where feasible, had installed it. Transferability is a very difficult thing to do. We did a study some years ago, created a matrix on the transferability, and the solutions to those, and then arrayed them as to the severity of the problem and the probability of solution. One of the early ones, that has since been changed, was in the area of proprietary rights. LEAA was a prime example. They would make grants. A vendor would go in and put in a system, have proprietary rights to it, transfer it to a second State, and charge 100 percent of the costs again. I think most of the Federal agencies, in their regs, now say that anything developed with Federal aid shall be in the public domain.

Another problem we had was the NIH, the "not invented here syndrome." This is very difficult for technical people. I don't know what it is with the administrators, but somehow or other, they want to do it themselves, do it inhouse. Maybe their salaries are dependent on it. But there is a resistance to transfer.

In a lot of the old standard administrative systems, the problem is the embedding of administrative detail in the statutes. We went to put in a central payroll in Wisconsin, and the statute said, "You will pay on the last day of the month, for that month." We were running somewhere about 20 percent cancelled checks because to get a payroll out at that time, we had departments starting to write their payrolls on the 10th of the month. It's pretty hard to guess who is going to resign, transfer, or die in that other two thirds of the month. Another thing it said in there is that you shall recess for lunch from 11:45 until 12:30. We wanted to go to a standard 80-hour period. We wanted to go to flextime, in some cases 10-hour days. We wanted to change the accumulation of sick leave and annual leave. And it took us two legislative sessions to get that administrative detail out of the statutes. Before I left Minnesota, somewhere around 1957 or 1958, we put in a central payroll. The State auditor said that the salaries are on a monthly basis. And, originally, you always waited to retire in February because your daily rate of pay was higher in the short month than it was in the 31-day month. And we had a hell of a time. We finally convinced him that if we took the monthly salary and multiplied it by 12, and divided it by 2088, and then carried it out to six decimal places, we would be all right.

I did that in Wisconsin. I had somebody call me up from the Governor's office, and said, "If you do that, in 400 years, you are going to owe me $37 and some odd cents." And I told him to write me a letter in 400 years, and I would pay him. And if you took a pay plan that had been approved, and changed it to 2080 hours, you would be overpaying somebody by eight or ten hours. So, you go through all of these things. But these are some of the problems of transfer.

The early histories of transfers were very evident. The Bureau of Public Roads, the predecessor of the Federal DOT, really fostered transfers. It was that operation that got me out of being a budget analyst and made me a "data processing expert." What you were doing was working with formulas, cut and fill, earth work computations. They were all formulas that could be reduced to a standard operating procedure. You put in the amounts; you cranked it up; and, the formula came out. And BPR did a lot of work in fostering transfer. The other organization was the U. S. Department of Labor, which has some very rigid accounting procedures and reporting procedures. And seeing as they pay 99.9 percent of all State economic security operations, their claim to uniformity was pretty great. "You can either give us the report, or we don't give you the money," and that has great effect. So, those got done. We did transfer one payroll system. We took the entire Ohio system, payroll and personnel system, and moved it to West Virginia. The only reason we were able to do that is the Governor, by executive order, could decree that everything set up under the prior payroll system was wiped out, and you could start from scratch. We have transferred one accounting system with which your entries and disbursements, everything is done from 300 or 400 terminals. It was moved to Vermont. But, again, the same situation prevailed, that somebody was strong enough to wipe out impediments. This does not often happen. So many times it is in the statute and requires a long time for change.

The real winners, that we have seen in transfer, are among you people. Fostered by Federal governments, MMIS was transferred out of Oklahoma to several places. Agriculture had Fannie Prudent, which was a menu planning device. And we hope that the Federal Aid Management System wil also be in a transferable mode. These were done because they were new programs. You had no long legislative history. You had no long administrative history. There was some 90/10 money involved, which was a very great incentive. And the other thing is that there were people involved. One of the things we found, that makes a transfer viable, is if people from the donor State can go to the recipient State and work with those people. Just sending them paperwork is very difficult. There, I assume, almost always has to be some modification, and it's hard to modify. But if the donor State can have people go, spend a couple of weeks, find out what the recipient State is really doing, then there is a communication link set up which, over the period of the transfer, makes it viable.

I think this is one of the important things that we have recognized, and this occurred in the Ohio-West Virginia system, in which Ohio actually made three people available over a year and a half time, not to exceed X number of days per month. It happened in the MMIS sytem. One of the problems with it is if the donor State can afford to have somebody gone a third of the time, somebody is going to ask, "Do you really need that person on your payroll?" And that gets hard to justify sometimes.

There are consultants now working in new areas in the welfare field, the absconding parent, abused child, these types of records. And I was told that the second time that this consultant had installed a system, the cost to the second State was about 58 percent of the cost to the first State. We have always said we thought that you could save between 40 and 60 percent. I think that those figures verify the fact that there is a possible saving in the cost to the recipient State of a second installation.

In entering into consultant contracts, every effort should be made to make sure that that consultant will consider transfer from other States.

Again, I urge you if you are looking for a package, use NASIS. Your State has paid the dues. Our bulletin usually goes out about this time of the month, one or two paragraphs explaining what you are looking for. If hardware is a consideration, what kind of hardware it has to run on.

And I received a letter from a city -- I can't remember where -- but he said that he had gotten 19 responses. I would guess usually you might get somewhere more like five or ten, but he said he got 19 responses to some kind of a system he was looking for. So, our people do respond to these things, and I think you should make use of them.

There is Federal action going on in transferability by the VA hospital in Kansas City which has been doing a major study on it. This study should be published sometime by the end of this year, which talks about the human element and the equipment element in transfers, what things can be modified and what things make the transfer impossible. Again, that report will go out to all the States, and I hope that it will be spread around.

There are several States -- I mentioned Minnesota -- where the budget office is now getting into the act. They are saying, "Before you come up with a major system, it must be reviewed and signed off by the budget office." More and more States are getting a computer audit capability in their post audit groups, and they are starting to ask the question, "How did you develop this particular system, and why, and what have you done about it?" Thinking about what I was really going to say, and these come out of a Congressional Office of Technical Assessment project I have been working on, a couple of caveats came to mind that I would like to leave with you as they affect automation of welfare programs. One is short term, but with the tightening of the Federal budget, the probable elimination of the State portion of the Federal revenue sharing, that any overexpansion of data processing in the name of efficiency may, in the short term, result in a diminution of the resources available for direct assistance to the constituency. You go out and spend a lot of money putting in some great big distributed processing system, and three years from now, that may work. But the money you spend on that during the next three years might be better spent in direct assistance to your clientele.

I also have a long term concern about how far we go in the name of efficiency, and this is kind of heresy in some ways. At one time, I thought anything you could do in the name of efficiency was right. But I am becoming concerned about distributed data processing, stand along minis, in that they are creating an exposure to information that may cause severe infringements on the rights and dignity of the constituency. I think you will see this in the Office of Technology's assessment report on information systems. This is recommendations to Congress, that it's one thing to have it in one room, locked up in one file, with all kinds of inscription and passwords, but it is another to have that information out in a series of terminals. And this has been proven, by the way. A check in one State, where the password, the sign on of a person who had left six months before, had gone through three other people, with nobody ever having control of it.

And I think it was the sheriff in Du Page County, Illinois or one of his people, that was furnishing information to a truck company in St. Louis. There were five police officers in Boston that were furnishing off information to a credit agency and to private detectives. And as this information that you have on your welfare clientele starts moving out into the distributed processing area and to the remote terminal systems, unless there is extreme care taken, you are going to have a quantum jump in the exposure that those records are going to have to misuse.

CONFERENCE WRAP-UP

For the States:

Warren Peterson
Director, Systems Division
Minnesota Department of Public Welfare

For the Private Sector:

Norman Nicholson
National Medicaid Manager
Electronic Data Systems

For the Federal Government:

Dick Rice
Computer Analyst
Medicaid, HCFA, RO III

William Hogsten
Acting Director, Office of Methods
and Systems, BPO, HCFA

MR. PETERSON: I'm pleased to have the opportunity to have attended this conference. I was unable to attend the one in Albuquerque so I have no basis to compare the two. It has become fashionable to rate things on a scale from one to ten these days, and I guess my judgment would be about an eight, which I'd say is pretty darn good. The coverage has been broad and the topics have been interesting. There have been some problem areas, however, that have not been dealt with very extensively. We heard a little bit this morning about some long term care reports, but I would really like to see more on some of the other issue areas of long term care. This is a critical area in our State with well over 55 percent of our Medicaid budget going directly to long term care, and the 15 percent or so of our eligible universe that occupies long term care facilities consume well over three-fifths of the budget. It is an area in which many of the costs are not within our control. I hope that somebody is going to come up with some solutions that they'll be able to share with us in that area at some future time.

There are a few other matters beyond the conference that I'd like to make reference to, because I think they somewhat underlie what we have been discussing. They do deal with some of the things that were shared in the material that was passed out, the discussion papers that were given out in our materials. Certainly, I think most of us would be in general agreement with the initiatives for uniform coding structures or labels, as we are calling them now. Actually, I think we've been seeking this kind of Federal leadership, at least some of us have, for a good many years, and we're pleased to see that things are starting to move in that direction. We ask only that there be reasonable time in implementing these changes and that there be funding available that is quite readily approvable in order for us to make the necessary implementations.

With reference to the common invoice, we do have some concerns. Several States, and I don't want to represent that I'm speaking for all, have a problem with a common invoice if it precedes the common coding structures and data elements. It is something of a fiction in terms of meeting the real goal of ease of provider completion and cost reduction that results. One of the risks is that it may appear to be a major step forward, when it is not really that -- if the provider must use multiple manuals of computer programs to complete that common invoice.

Another thing that I'd like to emphasize -- and I think everybody knows that we're a scanning State -- is that that invoice has to be scannable. You can always key enter from a scannable invoice, but you can't scan one that isn't designed for it.

We have been hearing quite a lot about a move towards integration between the two programs, Medicare and Medicaid. I think that there are some real pluses in moving as far as reasonable in that direction, but I think it's very important to keep in mind that these two programs, though serving health care needs of significant parts of our society, have some very basic, essential differences that we must not lose sight of in that process and among those differences is the basis for administration of these programs. There is something substantially different about dealing with the sovereign States and dealing with contractors, and this does need to be recognized and accommodated.

There are also some very basic differences in the thrust of the programs; Medicare is essentially an insurance program that meets a portion of need, the Medicaid program, of course, must meet the full need and must keep the providers in the business of providing services to the client community.

Some of the materials that have been distributed have to do with the concern about burden and reduction of burden. There seems to be no end to the increase in complexity in coverage by regulations. We need to more than hear the words; we need to see the action of reduction of burden. I think one test might be what happens now in relation to the proposed EPSDT reporting requirements. I have the impression that they may be about to come out; on the other hand, these are some rather onerous requirements that I think go well beyond the requirements of statistical reporting but, in essence, go towards monitoring the program itself. As we all know, there is a great deal of monitoring in that program as it is now.

One concluding note, though, is that I think these conferences provide a reason for some optimism in being able to work out some of the conflicts that I see. I may be sounding a bit paranoid, as a State in this environment, but I think it needs to be understood by HCFA that the States are feeling very much in the minority. We see an administrative organization that is heavily oriented to the Medicare program and, we have to keep communicating about this in coming to an understanding of the very essential differences that exist between these programs.

MR. NICHOLSON: In looking at what's transpired in the last two and a half days, and trying to summarize from a contractor perspective, I can net out a few major points. The contractors and the subcontractors are merely an extension of the State agency. Our view and our perspective is that we would like to be part of the team, part of the State agency team. Conferences like this give us the opportunity to be part of that team, to share our ideas, our thoughts, our precepts with you. That doesn't mean that we expect you to accept all of them and to apply all of them, but the ability to voice those and to express our opinions is certainly important, from our perspective.

We appreciate the opportunity to fellowship and to get to know each one of you better and to share our ideas with you. In looking at contractors, I would summarize with this. If I try to put myself in the position of the State administrators, I would say there are several things that you can look at. You need to look at the products that are being offered by the contractor, and there are many different types of products that are being offered. And with each one of those products comes a level of service, and that level of service is determined by several things. One of those things is the incentive that the contractor has to go in one direction or another.

Let me give you some specific examples of what I'm speaking about. If you hire a contractor just to install an MMIS system for you, what we refer to in the industry as a turnkey type of system where they install the MMIS, train your clerical people and your data processing people to operate that system, the incentive for the contractor is getting the system in. The contractor makes his profit form the difference between what it costs to get the system installed and what you are paying. The incentive is to meet the requirements of the RFP, but to do that at a minimum expense, so he is mainly interested in getting the system installed and meeting your requirements. His motivation is not necessarily for the efficiency of the data processing system.

If you take the next level of product that's offered, which I call "facilities management", there's a change in the motivation of the contractor because of the incentive. That contractor makes money based on the ability to operate the data processing system efficiently, since he is supplying you with a data processing service and is responsible for the operation of that data processing system and he makes his profit through the efficiency of that data processing system. So, in a facilities management type of product, you will probably receive a fairly efficient data processing system if the subcontractor has had an opportunity to operate that MMIS system.

If you take it the next level up to a fiscal agent type of product, then the incentives there are for an efficient data processing system, but also for an efficient clerical operation, because the contractor is getting paid for the entire operation, so the motivation is a little bit different. He might put some things into the data processing system that would make the clerical operation much more efficient.

Then you can take it one level above that, which is really where the big dollars are in the Medicaid program in the benefits side, and if there is some way where the subcontractors can be responsible for and really on risk for the benefit dollars that are being disbursed in the Medicaid program, then the subcontractor has, in my opinion, the greatest overall incentive for the total product that I think that you're looking for in the administration of the Medicaid program, and you're looking for benefit dollar control, administrative dollar control; you're looking for fast and accurate claims processing and high quality of claims processing.

I think conferences of this type are excellent. It gives us an opportunity to exchange ideas, and to express our opinions. And we are very grateful for such opportunity. We appreciate the invitation and the opportunity to share our concepts and perceptions of what we think will happen in the future. I just wanted to express that on behalf of all of the subcontractors.

MR. RICE: In conforming to what Mr. Hogsten said in his opening remarks, "a brief summary," I will assure you that in my career I have been noted as a man of few words and therefore you can rest assured that I will not destroy my reputation.

I think the basic lesson, if you want to call it that, that we, as regional analysts, can learn is that each region has different problems and different solutions to these problems, and if we, coming from one region, can accept the solutions to these problems as demonstrated in other regions and take them back into our region, this can make the conference a very worthwhile performance.

Also, the innovative approach, such as in New York City where they are undertaking the development of a dial-up provider inquiry to check eligibility, is something that I've heard some of the State representatives talk about as something they may want to check into. Of course, each area has their own little problems.

As far as I am personally concerned, before I left the regional office on Friday afternoon, our regional EPSDT coordinator asked me to make sure that I got all the documentation I could on the presentation being made by the Michigan person; also to get the name and the phone number.

Another example of the learning process that I, personally, was involved in, as a regional analyst, and can be, I'm sure, shared by all of my counterparts throughout the country, are some of the problems that are brought up by States outside of our region. For example, in the session on State assessments, it was pointed out that, too often, we Feds go in there, one after another, asking the same questions that somebody just finished asking. Therefore, when it comes time for State assessments, as we and every State are going to be involved in, theoretically, on an annual basis, it's the responsibility of the regional analyst to make sure that as little overlap as possible takes place. If possible, we must use that data which has already been developed by the HEW audit or by the financial management specialists who've gone in.

Finally, I think the biggest job that we have as regional analysts, as the primary contact between HCFA and the States -- direct representatives, if you will, of Leonard Schaeffer -- is to remove our stigma Lie Number 3 from the list of ten most used lies in this country, as delineated by Charles McDermott of Oklahoma in one of the sessions yesterday, the first lie being, "Yes, the check is in the mail"; the second lie being, "Yes, I will respect you in the morning"; and in our case, "Hi, I'm from the Federal government, and I'm here to help you."

MR. HOGSTEN: From the central office perspective, it's the general consensus, I think, that the objectives of the conference have been pretty well met. The objective, of course, was basically to provide the opportunity to open communications with respect to major initiatives; to have dialogue with concerned parties with respect to those initiatives; and, also then to provide an opportunity and an environment for exchange of ideas among the various represented groups that are important in the management of the program.

I would have to say that the conference emphasized program management, management as opposed to process, even though process has to enter the picture. The MMIS effort is a combination of a better way to do business, with claims process a very primary focus, and is intended to be a dynamic management tool through which to better manage programs, to do better planning, and so forth.

I think, from the Federal perspective, the dialogue is particularly important to us. We have that dialogue in various ways. Much of the value comes out of the individual discussions. It should be guiding to us in terms of realization of some of the concerns, as we move in major directions of change.

As the discussion papers will indicate, there is a great emphasis placed upon the need for dialogue for all of those who have a role to play in the health care delivery system and especially in the reimbursement mechanisms.

So I hope that the wave of the future looks good from your perspective in terms of HCFA's desire to have meaningful communcations, two-way communications, so that when we are setting direction, we are setting direction that will really result in improved administration.

During the conference, there were some points brought out that maybe should be highlighted. There is more need, as we establish direction, for States to be aware of how that direction is changing or how it is progressing. The important thing is that such knowledge must be a part of good State planning. We attempt to do some of that through conferences of this type. I think we can make greater use of some of the written vehicles that we have within HCFA, e.g., publications. We perhaps need to make a little greater use of the information type issuances that we have in order to keep States abreast of what's really happening.

As you know, we had some discussion this morning about the Systems Technical Advisory Group (STAG). There are a number of technical advisory groups that have been agreed to be established within the Council of State Medicaid Directors, nine of them, as I recall. The concentration this morning was on the one that is closer to what this group represents, and that's systems.

Those mechanisms are, I think, important. They should be addressing issues from the standpoint of what it means, particularly in the systems area or in the other eight areas that have been identified. I hope that moving through change in direction, will be done a meaningful way, with input from the group. The STAG has had some substantial exposure to some of the major issues that we are attempting to address.

The issue of Medicare control seems to emerge in the organizational setting. This is one of the observations that's frequently made that there are those in Medicare who are basically responsible now for the direction of the Medicaid program and there needs to be much more insight on the part of the staff with respect to the Medicaid program and its administration. I hope, through dialogue and action, we can establish ourselves in such a fashion that good management will be accepted as our joint objective.

Several issues were raised with respect to what's meant by 90 percent-75 percent funding and what are the conditions, and so forth. I think we need to address those issues much more definitevely with respect to the sorts of guides that we have. Later this year, I hope that we will have done something -- we have a document now that would go some distance in helping to define, and what we are trying to do is to have something that could be used nationally, that would be meaningful in terms of how 90 percent and 75 percent funding would be approved for what sorts of items.

There is another expressed concern with respect to change in direction as represented through MMIS requirements that we dealt with in terms of the regulation. It says change must take place and we have an organized method, through that regulation, to announce change and allow time and funds to adjust to those changes.

An observation was made that in the 90 percent area we require an APD if we're going to approve 90 percent. What we hope to do, when we do see the results of change that is enunciated through the public announcement process, is to find a simpler way in which to address the cost, the funding of those things and still meet, basically, the APD requirements. A simpler method simply would be one of perhaps defining an abbreviated submission that would not require having to go through the complete APD process as we generally perceive that process. That would have to be defined, of course. There is no way, of course, we could subvert the 95 reg requirements and threshold amount provisions.

From our perspective then, I think that essentially covers points that I wanted to make. I think each will make his own judgment as to the value of the conference. I hope each of you got out of the conference what you expected. It has certainly been quite beneficial from the Federal perspective.

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